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National health expenditures, 1985

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Highlights

Expenditures for health care in the United States rose to $425 billion in 1985, growing 8.9 percent since 1984 (Table 1). Despite slow growth, the lowest recorded in the past 20 years, expenditures increased as a percentage of the gross national product (GNP) from 10.3 percent in 1984 to 10.7 percent in 1985 (Figure 1). Highlights from the 1985 National Health Accounts include the following:

- An average of $1,721 per person in the United States was spent on health care.
- Direct patient payments, amounted to $106 billion in 1985. After many years of steady decline in the proportion of personal health care spending accounted for by direct patient payments, this component has stabilized at 28-29 percent of the total over the past 7 years.
- Public programs financed 41 percent of all health expenditures (Figure 2). The Federal share of health expenditures has steadily increased. Federal programs financed 29 percent of all health care in 1985.
- Medicare benefit payments grew 12.2 percent, more than one-third faster than the growth in all personal health care expenditures. The result was that the Medicare program financed 19 percent of all personal health care in 1985, up from 16 percent in 1980.
- Medicare's prospective payment system (PPS) for inpatient hospital services did little to slow expenditure growth by the Medicare program. Medicare expenditures for hospitals grew 10.1 percent over the 1984 level, more than 60 percent faster than non-Medicare hospital expenditures.
- Medicare expenditures for physicians' services grew at twice the rate of non-Medicare expenditures for these services.
- The Medicaid program, including the Federal and State shares, paid out $40 billion in benefits, 10.7 percent of all personal health expenditures.
- Together, the Medicare and Medicaid programs financed 30 percent of all personal health care services.
- The Nation's bill for hospital care was $167 billion, 45 percent of all personal health care costs. Hospital expenditures rose 7.3 percent in 1985, faster than the 5.8-percent growth in 1984.
- Growth in expenditures for physicians' services, 9.9 percent in 1985, was the lowest in more than a decade, resulting in spending for physicians' services of $83 billion.
- The portion of nursing home expenditures paid by Medicaid has been falling over the last 6 years. In 1985, 42 percent of all nursing home costs were paid by Medicaid, down from a high of 49 percent in 1979.

National health expenditures

Spending for health care in the United States climbed to $425 billion in 1985 (Table 2), averaging expenditures of $1,721 per person. Growth slowed to 8.9 percent in 1985, the slowest growth in national health expenditures in the past 20 years.

Despite the deceleration in growth, health expenditures as a percent of the GNP increased to 10.7 percent, well above the 10.3 percent recorded in 1984. (See the Definitions, Sources, and Concepts section of this report for a discussion of the Commerce Department's revisions to GNP levels.) The increase in health care as a percentage of the GNP can

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This article continues a series of reports begun in the Department of Health, Education, and Welfare (Reed and Rice, 1964). The series, now the responsibility of the Health Care Financing Administration, presents the National Health Accounts of the United States.

Table 1

National health expenditures aggregate, per capita, percent distribution, and annual percent change, by source of funds: Calendar years 1965-85

Item	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976	1975
						Amount in billions					
National health expenditures	$425.0	$390.2	$357.2	$323.6	$287.0	$248.1	$214.7	$189.7	$169.9	$150.8	$132.7
Private	250.2	230.7	209.7	188.4	165.8	142.9	124.2	110.1	100.1	88.0	76.4
Public	174.8	159.5	147.5	135.3	121.2	105.2	90.5	79.6	69.7	62.8	56.3
Federal	124.4	111.7	102.7	93.2	83.3	71.0	61.0	53.8	47.4	42.5	37.0
State and local	50.4	47.8	44.8	42.1	37.9	34.2	29.5	25.8	22.4	20.3	19.3
						Per capita amount					
National health expenditures	$1,721	$1,595	$1,473	$1,348	$1,207	$1,054	$921	$822	$743	$665	$590
Private	1,013	943	865	784	697	607	533	477	438	388	340
Public	708	652	608	563	510	447	388	345	305	277	250
Federal	504	456	424	388	350	302	262	233	207	188	165
State and local	204	195	185	175	159	145	127	112	98	89	86
						Percent distribution					
National health expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	58.9	59.1	58.7	58.2	57.8	57.6	57.9	58.0	58.9	58.4	57.5
Public	41.1	40.9	41.3	41.8	42.2	42.4	42.1	42.0	41.1	41.6	42.5
Federal	29.3	28.6	28.8	28.8	29.0	28.6	28.4	28.4	27.9	28.2	27.9
State and local	11.9	12.3	12.5	13.0	13.2	13.8	13.7	13.6	13.2	13.5	14.5
						Annual percent change					
U.S. population	0.9	0.9	1.0	1.0	1.0	1.0	1.0	0.9	0.9	0.8	0.9
Gross national product	5.7	11.0	7.4	3.7	11.7	8.9	11.5	13.0	11.7	11.5	8.5
National health expenditures	8.9	9.2	10.4	12.8	15.7	15.6	13.2	11.7	12.7	13.6	14.3
Private	8.5	10.0	11.3	13.6	16.0	15.1	12.8	10.0	13.8	15.2	10.5
Public	9.6	8.1	9.1	11.6	15.2	16.2	13.7	14.1	11.1	11.5	19.8
Federal	11.4	8.7	10.2	11.9	17.3	16.4	13.4	13.5	11.5	14.7	21.8
State and local	5.3	6.8	6.4	11.1	10.9	15.8	14.4	15.3	10.2	5.2	16.0
						Number in millions					
U.S. population[1]	246.9	244.7	242.5	240.2	237.8	235.3	233.0	230.8	228.7	226.7	224.9
						Amount in billions					
Gross national product	$3,989	$3,775	$3,402	$3,166	$3,053	$2,732	$2,508	$2,250	$1,991	$1,783	$1,598
						Percent of gross national product					
National health expenditures	10.7	10.3	10.5	10.2	9.4	9.1	8.6	8.4	8.5	8.5	8.3

See footnotes at end of table.

be attributed to slower economy-wide growth in 1985 as measured by the GNP, up only 5.7 percent, and to growth in health care spending, which, although the lowest in two decades, surpassed economy-wide growth.

With funds coming from private health insurance and direct patient payments, private expenditures continued to finance a majority of health care, 59 percent (Table 3). Public funds accounted for 41 percent of health expenditures in 1985. Increasing proportions of public funds flow from the Federal sector, primarily from the Medicare and Medicaid programs.

Personal health care

Personal health care expenditures rose to $371 billion dollars in 1985, or $1,504 per capita. Expenditures grew 8.9 percent, slightly faster than the 8.4-percent growth recorded in 1984.

Despite continued deceleration of health care prices, 63 percent of the 1985 increase in personal health care expenditures was because of inflation, with 23 percent specifically attributable to medical care price inflation. Growth in population accounted for 11 percent. Increases in the "intensity" (the interaction of changing demographics of the population, consumption patterns per capita, technology, and service composition) accounted for 26 percent of the growth (Figure 3).

The past 4 years have produced changes in the composition of personal health care expenditures. Hospital care as a proportion of personal health care expenditures rose steadily from 1965 to 1982, climbing from 39 percent to 47 percent. Changes in Medicare payment policies, in conjunction with changes prompted by the business community, reversed that trend, reducing the U.S. health system's reliance on hospital care. In 1985, less than 45 percent of all personal health care spending went for hospital services. The share of personal health expenditures going to physicians, other professionals, dentists, and nursing homes increased in the 1982-85 period, but the shares spent on durable and nondurable medical products remained constant.

Hospital care

Hospital expenditures in 1985 are estimated at $166.7 billion, up 7.3

Table 1—Continued

National health expenditures aggregate, per capita, percent distribution, and annual percent change, by source of funds: Calendar years 1965-85

Item	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965
					Amount in billions					
National health expenditures	$116.1	$103.4	$94.0	$83.5	$75.0	$65.6	$58.2	$51.5	$46.3	$41.9
Private	69.1	64.0	58.5	51.8	47.2	40.7	36.1	32.5	32.7	30.9
Public	47.0	39.4	35.4	31.6	27.8	24.9	22.1	19.0	13.6	11.0
Federal	30.4	25.2	22.9	20.3	17.7	16.1	14.1	11.9	7.4	5.5
State and local	16.6	14.2	12.5	11.4	10.1	8.9	8.0	7.0	6.1	5.5
					Per capita amount					
National health expenditures	$521	$467	$428	$384	$349	$309	$276	$247	$224	$205
Private	310	289	267	238	220	191	171	156	158	152
Public	211	178	161	146	129	117	105	91	66	54
Federal	136	114	104	93	82	76	67	57	36	27
State and local	75	64	57	52	47	42	38	34	30	27
					Percent distribution					
National health expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	59.5	61.9	62.3	62.1	63.0	62.0	62.0	63.2	70.7	73.8
Public	40.5	38.1	37.7	37.9	37.0	38.0	38.0	36.8	29.3	26.2
Federal	26.2	24.4	24.4	24.3	23.6	24.5	24.2	23.2	16.1	13.2
State and local	14.3	13.7	13.3	13.6	13.5	13.5	13.7	13.7	13.2	13.0
					Annual percent change					
U.S. population	0.8	0.8	1.0	1.1	1.1	1.0	1.0	1.0	1.2	2.0
Gross national product	8.3	12.1	10.0	8.6	5.3	8.0	9.3	5.8	9.5	6.5
National health expenditures	12.3	10.0	12.6	11.3	14.3	12.7	13.1	11.2	10.3	9.3
Private	7.9	9.3	12.9	9.8	16.0	12.7	11.1	(0.6)	5.8	8.8
Public	19.4	11.1	11.9	14.0	11.4	12.8	16.6	39.8	23.4	10.6
Federal	20.8	9.9	12.9	14.8	9.9	14.0	18.4	60.1	34.5	12.9
State and local	17.0	13.3	10.3	12.5	14.0	10.8	13.6	15.1	12.1	8.5
					Number in millions					
U.S. population[1]	223.0	221.3	219.5	217.4	215.1	212.7	210.7	208.6	206.6	204.1
					Amount in billions					
Gross national product	$1,473	$1,359	$1,213	$1,103	$1,015	$964	$893	$816	$772	$705
					Percent of gross national product					
National health expenditures	7.9	7.6	7.7	7.6	7.4	6.8	6.5	6.3	6.0	5.9

[1]July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

percent from 1984. Despite an acceleration in the growth rate for 1985, growth in hospital expenditures remained below the double-digit rates experienced during the 1970's and early 1980's. With hospital spending growing at a slower pace than the overall category of personal health care during the 1983-85 period, its share has been falling, from a high of 47 percent in 1982 to 45 percent in 1985.

The primary payers of hospital care are private health insurance and the Medicare program. The share of hospital care funded by private health insurance dropped from 38 percent in 1980 to 36 percent in 1985. Moving in the opposite direction, the Medicare share of hospital costs rose from 26 percent to 29 percent over the same period. Implementation of Medicare's prospective payment system (PPS) produced merely a blip in this trend. During the same period, direct patient payments' share of the total hospital bill rose from 8 percent to 9 percent, continuing a trend begun in 1978.

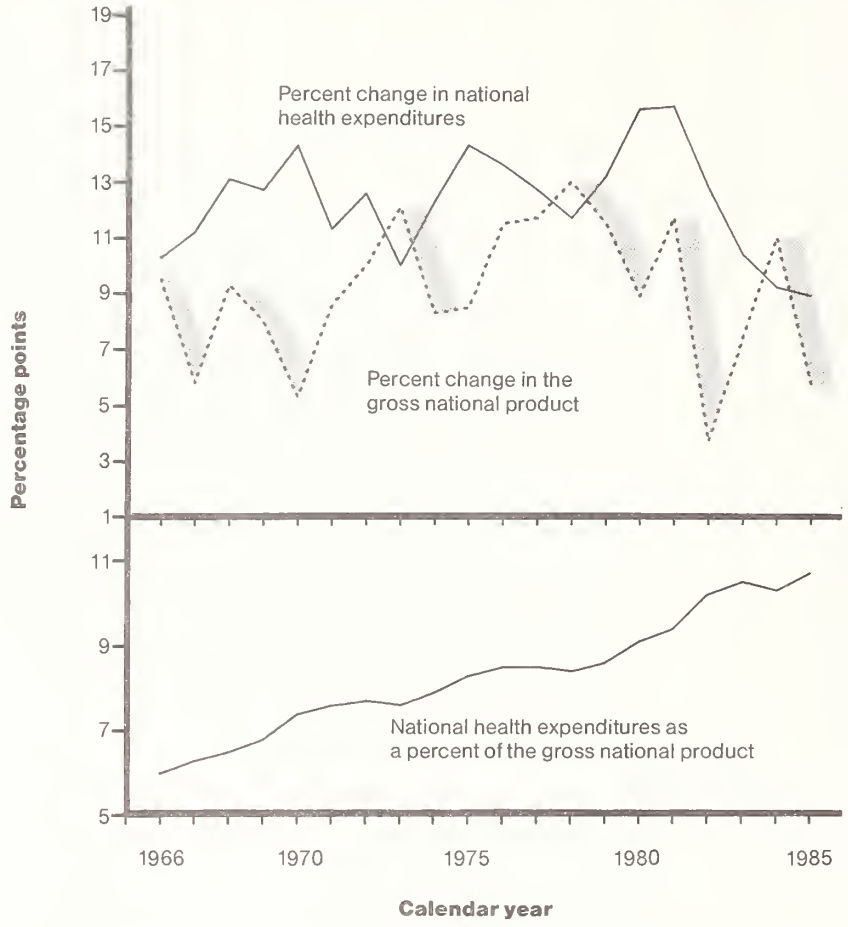
According to the American Hospital Association's panel survey of community hospitals, admissions and inpatient days continued the strong decline first noticeable in calendar year 1983. Average lengths of stay, 5.5 days for patients under 65 years of age and 8.8 days for those 65 years of age or over, were the lowest ever recorded. Increasing numbers of outpatient visits partially offset the declining inpatient utilization.

Hospitals' response to declining inpatient utilization can be seen in the reduction of resources. The number of beds continued to decline in 1985, down 2.9 percent since 1983. In addition, the number of full-time equivalent personnel dropped, although the number per 100 census and per 100 adjusted census (adjusted to reflect outpatient care) continued to rise. Increases in the intensity of personnel usage per 100 census are expected because persons remaining in the inpatient setting are "sicker" and require more services that those previously using inpatient hospital services.

Outpatient revenue, comprising almost 17 percent of patient revenue

Figure 1

Percent change in national health expenditures and gross national product, and national health expenditures as a percent of gross national product: Calendar years 1966-85



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Spending for health generally has increased faster than has the gross national product (GNP), so that health expenditures are rising as a share of GNP.

in 1985, is playing an increasing role in hospital finances as both private and public insurers press for reduced costs. Many procedures previously performed on an inpatient basis are being switched to an outpatient setting. In addition, increases in preadmission testing occur as pressure to reduce the length of stay heightens.

Both patient and total revenue margins in community hospitals declined in 1985, but those margins for calendar years 1984 and 1985 remain the highest levels ever recorded. Hospitals' total revenue (including patient revenue, revenue from other operations, contributions, interest, tax subsidies, etc.) exceeded expenses by 5.9 percent during 1985, down slightly from the 6.2-percent level of 1984. Patient revenue was 1.5 percent higher than total expenses in 1985.

As payers increase pressure on the hospital industry to reduce costs, questions about the quality of care and accusations of premature discharge of patients become issues that the industry and insurers must resolve. The problem of care for the indigent population not covered by public programs increasingly casts a shadow on the hospital industry. Payers are unwilling to have the cost of indigent care shifted to them, and hospitals, concerned about their ability to balance expenses and revenue, are forced to deny care to those who cannot pay for it. In some States, legislation has been passed that imposes severe penalties for hospitals that refuse care or attempt to have indigent patients whose condition is not stabilized transferred to a public facility.

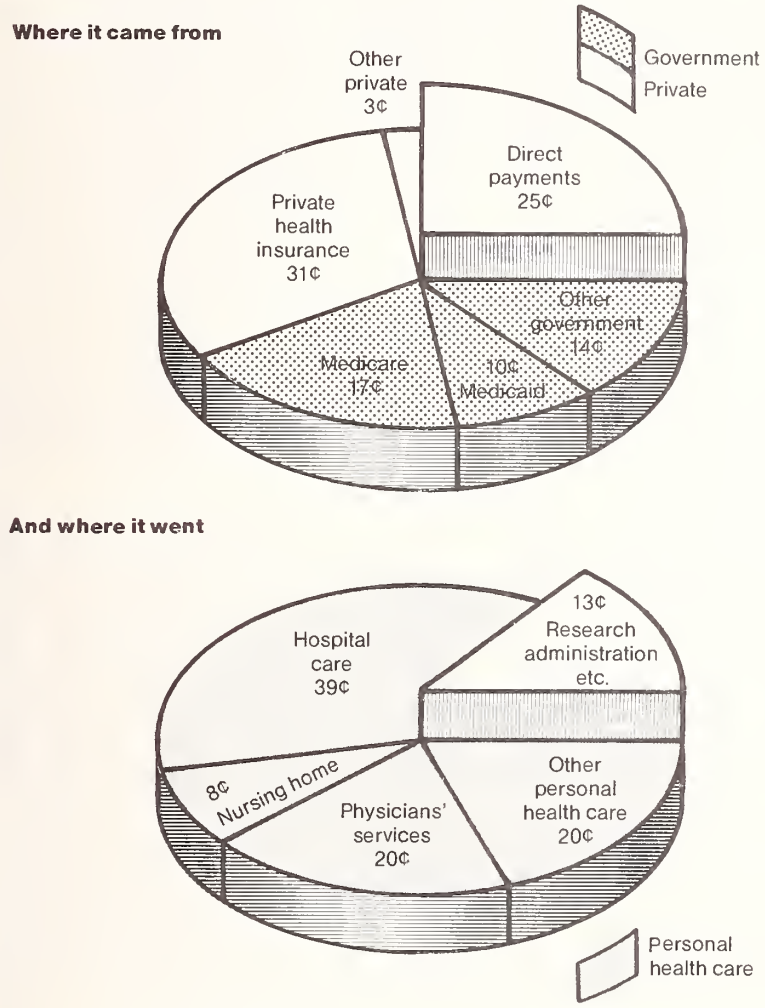
Physicians' services

Gatekeepers for the health care system, physicians are a shaping force for that system. They have a major say in who will be admitted to a hospital and what course of treatment will be followed there. They also are the principal source of prescriptions for drugs. In that sense, physicians' influence over national health expenditures stretches far beyond the money spent for their services alone.

Recent developments in the health care system have reduced the autonomy of physicians. The implementation of prospective payment mechanisms and of use review has led hospital management to examine admissions and lengths of stay much more closely than they did before. Insurers also are becoming much more active in use review, and patients are encouraged to seek second and third opinions before undergoing major procedures. Despite these and other developments, physicians as a group retain the significant voice in answering the question, who will receive how much of what care?

In 1985, $83 billion were spent for the services of physicians, 22 percent of all spending for personal health care. Three payers accounted for more than 90 percent of the money going to physicians. Private health insurance accounted for 45 percent of the total, Medicare benefits for 21 percent, and direct patient payments (including deductibles and coinsurance for both Medicare and private insurance) for 26 percent. This category of expenditures includes spending for services received through offices of physicians and surgeons, offices of

Figure 2
The Nation's health dollar: 1985



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

During 1985, 75 percent of all health expenditures were paid by third parties—government, private health insurance, philanthropy, and business—and 87 percent of the spending went for personal health care.

osteopathic physicians, and independent medical laboratories, as well as benefits provided by health maintenance organizations' salaried physicians.

That the growth of expenditures for physicians' services, 9.9 percent from 1984 to 1985, was the lowest in more than a decade is attributable to changes in price inflation. The 1985 annual Consumer Price Index for physicians' services was only 5.8 percent higher than the 1984 Index, extending a 4-year deceleration of growth.

The mix of services provided by physicians has been undergoing a radical change. Over the last 5 years, community hospital admissions have dropped 8 percent and community hospital inpatient days have dropped 16 percent (according to the American Hospital Association's panel survey of community hospitals), meaning that physicians are seeing far fewer of their patients in a hospital setting. On the other hand, emergency room visits, after 4 years of decline, began to increase in numbers in 1985. Surgical operations performed in community hospitals increased 3 percent from 1980 to 1985, a rate somewhat lower than the recent historical trend. Although firm data are not yet available, we believe that the number of office visits has increased over the last few years because more pre- and post-hospitalization visits have been substituted for longer hospital stays. The estimates we used in preparation of these statistics on national health expenditures show a total increase in office visits of 9 percent from 1980 to 1985.

Evidence exists that activity has increased in the offices of physicians. Data from the Bureau of Labor Statistics show that total employment in offices of physicians (Standard Industrial Classification 801) increased 5.3 percent from 1984 to 1985 and that aggregate hours worked per week by nonsupervisory personnel in physicians' offices increased 4.2 percent.

Dentists' services

Americans spent $27 billion for dental services in 1985, most of it through private health insurance programs or out-of-pocket expenditures. The increasing share of dental services covered by private insurance—34 percent in 1985, compared with 14 percent in 1975—has mitigated the strength of the traditional tie between real income and consumption of dental services. Thus, price-deflated spending for those services grew 3.6 percent in 1985, a year in which real disposable personal income grew only 1.6 percent.

Little government funding is available for dental services. In 1985, 64 percent of such expenditures came from consumers' pockets, and another 34 percent came from private health insurance benefits. Medicaid, source of the largest government payments, devoted only 1 percent of its benefits to dental services.

Activity in offices of dentists continued to increase in 1985, but at a

Table 2

National health expenditures aggregate and annual percent change, by type of expenditure: Calendar years 1965-85

Type of expenditure	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976	1975
						Amount in billions					
National health expenditures	$425.0	$390.2	$357.2	$323.6	$287.0	$248.1	$214.7	$189.7	$169.9	$150.8	$132.7
Health services and supplies	409.5	374.5	341.8	309.4	273.8	236.2	204.2	179.9	160.7	141.7	124.3
Personal health care	371.4	341.1	314.7	286.5	254.7	219.7	189.7	167.4	149.1	132.8	117.1
Hospital care	166.7	155.3	146.8	135.2	119.1	101.6	87.0	76.2	68.1	60.9	52.4
Physicians' services	82.8	75.4	68.4	61.8	54.8	46.8	40.2	35.8	31.9	27.6	24.9
Dentists' services	27.1	24.6	21.7	19.5	17.3	15.4	13.3	11.8	10.5	9.4	8.2
Other professional services	12.6	10.9	9.3	8.0	6.8	5.7	4.7	4.1	3.6	3.2	2.6
Drugs and medical sundries	28.5	26.5	24.5	22.1	20.7	18.8	17.1	15.4	14.1	13.0	11.9
Eyeglasses and appliances	7.5	7.0	6.2	5.8	5.3	5.1	4.7	4.2	3.7	3.4	3.2
Nursing home care	35.2	31.9	29.4	26.7	23.9	20.4	17.4	15.1	13.0	11.3	10.1
Other personal health care	11.0	9.4	8.3	7.4	6.8	5.9	5.1	4.8	4.2	4.0	3.8
Program administration and net cost of private health insurance	26.2	22.6	17.1	13.5	10.6	9.2	8.6	7.5	7.5	5.1	4.0
Government public health activities	11.9	10.9	9.9	9.3	8.5	7.3	5.9	5.0	4.0	3.8	3.2
Research and construction of medical facilities	15.4	15.6	15.4	14.3	13.2	11.9	10.4	9.8	9.2	9.0	8.4
Noncommercial research[1]	7.4	6.8	6.2	5.9	5.6	5.4	4.7	4.4	3.9	3.7	3.3
Construction	8.1	8.9	9.2	8.4	7.6	6.5	5.7	5.3	5.3	5.3	5.1
						Annual percent change					
National health expenditures	8.9	9.2	10.4	12.8	15.7	15.6	13.2	11.7	12.7	13.6	14.3
Health services and supplies	9.3	9.6	10.5	13.0	15.9	15.6	13.5	12.0	13.4	14.1	14.4
Personal health care	8.9	8.4	9.8	12.5	15.9	15.8	13.3	12.2	12.3	13.4	15.7
Hospital care	7.3	5.8	8.6	13.5	17.2	16.8	14.1	11.9	12.0	16.1	16.4
Physicians' services	9.9	10.1	10.7	12.8	16.9	16.4	12.4	12.4	15.6	10.6	17.4
Dentists' services	9.9	13.3	11.6	12.5	12.3	15.7	13.1	11.8	11.5	14.7	11.8
Other professional services	15.2	17.1	17.0	16.9	19.8	19.9	15.3	15.5	11.4	22.3	17.4
Drugs and medical sundries	7.4	8.4	10.6	6.9	10.4	9.5	11.1	9.6	8.1	9.1	8.6
Eyeglasses and appliances	8.3	12.0	6.4	9.4	5.6	7.8	13.0	12.5	8.3	8.3	13.3
Nursing home care	10.6	8.5	9.9	12.0	17.1	17.1	15.3	15.7	15.2	12.5	18.2
Other personal health care	16.0	13.2	13.0	9.2	14.2	15.4	8.1	12.1	6.7	5.5	21.8
Program administration and net cost of private health insurance	16.1	31.7	26.8	27.1	15.9	6.4	14.4	0.0	46.9	28.6	−14.3
Government public health activities	9.1	9.6	6.6	10.0	16.3	22.8	19.1	24.7	5.2	20.2	16.1
Research and construction of medical facilities	−1.2	1.6	7.7	8.4	10.3	14.5	6.8	6.5	1.6	7.4	12.5
Noncommercial research[1]	8.9	10.1	4.8	4.6	3.2	15.3	6.7	13.2	5.7	10.7	19.5
Construction	−9.0	−4.1	9.8	11.2	16.3	13.7	7.0	1.5	−1.2	5.1	8.3

See footnotes at end of table.

slower pace than in 1984. Aggregate hours worked by nonsupervisory personnel in those offices (Standard Industrial Classification 802) grew 7.5 percent from 1983 to 1984 and 3.0 percent from 1984 to 1985, according to data estimated by the Bureau of Labor Statistics. Nonsupervisory payroll grew 12.0 percent in 1984 and 9.3 percent in 1985. The trends in those rates reflect, among other things, the slowdown in growth of real personal income.

Price inflation moderated in 1985. The annual Consumer Price Index for dental services was 6.3 percent higher for 1985 than for 1984, the lowest annual change in a decade.

Other professional services

Spending for the services of health practitioners other than physicians and dentists came to $12.6 billion in 1985, including about $4 billion for home health services. Growth of this type of expenditure has been quite strong in recent years as patients seek alternatives to what they perceive to be more costly traditional forms of medicine.

About one-half of spending for other professional services in 1985 came from consumers directly. Another 20 percent or so came from private health insurance benefits, and the remainder from government programs, mostly home health care benefits from the Medicare and Medicaid programs.

Consumer durables and nondurables

A total of $36 billion was spent in 1985 for consumer durables and nondurables, and most of the payments came from consumer funds. This figure includes $7.5 billion for eyeglasses and appliances (durables) and $28.5 billion for drugs and medical sundries (nondurables). Of the latter amount, a little more than one-half is estimated to have been for the purchase of prescription drugs. The remainder was for purchase of nonprescription

Table 2—Continued

National health expenditures aggregate and annual percent change, by type of expenditure: Calendar years 1965-85

Type of expenditure	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965
					Amount in billions					
National health expenditures	$116.1	$103.4	$94.0	$83.5	$75.0	$65.6	$58.2	$51.5	$46.3	$41.9
Health services and supplies	108.6	96.5	87.4	77.4	69.6	60.8	54.1	47.6	42.6	38.4
Personal health care	101.3	89.0	80.5	72.2	65.4	57.1	50.3	44.5	39.7	35.9
Hospital care	45.0	38.9	35.2	31.0	28.0	24.2	21.1	18.4	15.8	14.0
Physicians' services	21.2	19.1	17.2	15.9	14.3	12.6	11.1	10.1	9.2	8.5
Dentists' services	7.4	6.5	5.6	5.1	4.7	4.2	3.7	3.4	3.0	2.8
Other professional services	2.2	2.0	1.8	1.6	1.6	1.5	1.4	1.3	1.2	1.0
Drugs and medical sundries	11.0	10.1	9.3	8.6	8.0	7.1	6.4	5.8	5.5	5.2
Eyeglasses and appliances	2.8	2.5	2.3	2.0	1.9	1.7	1.5	1.3	1.3	1.2
Nursing home care	8.5	7.2	6.5	5.6	4.7	3.8	3.4	2.8	2.4	2.1
Other personal health care	3.1	2.7	2.6	2.3	2.1	1.9	1.7	1.5	1.5	1.1
Program administration and net cost of private health insurance	4.7	5.3	4.8	3.5	2.8	2.5	2.7	2.2	2.1	1.7
Government public health activities	2.7	2.2	2.0	1.7	1.4	1.2	1.0	0.9	0.8	0.8
Research and construction of medical facilities	7.5	6.8	6.6	6.1	5.4	4.8	4.1	3.8	3.7	3.5
Noncommercial research[1]	2.8	2.5	2.4	2.1	2.0	1.9	1.9	1.8	1.6	1.5
Construction	4.7	4.3	4.2	4.0	3.4	2.9	2.3	2.1	2.1	2.0
					Annual percent change					
National health expenditures	12.3	10.0	12.6	11.3	14.3	12.7	13.1	11.2	10.3	—
Health services and supplies	12.5	10.5	12.9	11.2	14.5	12.4	13.6	11.8	10.8	—
Personal health care	13.8	10.5	11.6	10.4	14.5	13.4	13.1	12.2	10.6	—
Hospital care	15.7	10.6	13.5	10.9	15.4	14.5	15.0	16.6	12.9	—
Physicians' services	11.4	11.2	7.8	11.0	13.4	13.9	9.5	10.5	8.3	—
Dentists' services	12.8	16.1	11.0	6.7	13.2	14.3	9.3	13.4	5.5	—
Other professional services	13.0	9.5	10.7	2.1	8.4	3.3	13.2	8.5	12.2	
Drugs and medical sundries	9.4	7.7	8.8	7.3	11.9	11.3	11.4	5.5	5.5	—
Eyeglasses and appliances	10.3	11.5	14.0	2.0	14.0	15.0	17.5	–4.0	12.1	—
Nursing home care	18.4	10.3	15.6	20.0	23.4	12.6	21.8	17.8	13.7	—
Other personal health care	14.2	3.4	12.3	12.7	11.2	10.3	8.9	6.4	27.1	—
Program administration and net cost of private health insurance	–12.6	10.3	39.5	23.1	12.2	–8.0	22.0	7.0	20.1	—
Government public health activities	22.4	10.1	16.2	21.8	16.5	17.7	17.5	7.5	1.4	—
Research and construction of medical facilities	9.2	3.7	7.7	13.4	11.6	17.3	7.6	4.0	5.0	—
Noncommercial research[1]	10.6	7.2	11.2	7.5	2.4	2.5	6.2	8.4	7.5	—
Construction	8.4	1.7	5.9	16.8	17.7	29.6	8.8	0.5	3.1	—

[1]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but they are included in the expenditure class in which the product falls.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

drugs and analgesics and other over-the-counter items.

There is not much government purchase of these commodities. Public funds covered only one-tenth of spending for drugs and sundries, mostly through the Medicaid program, and two-tenths of spending for eyeglasses and appliances, mostly through Medicare. Similarly, private health insurance is less likely to cover these items than to cover other health care services. Private health insurance benefits paid for 14 percent of nondurables and 12 percent of durables consumed in 1985. Direct consumer payments for durables and nondurables came to $27 billion in 1985, constituting three-quarters of spending for nondurables and two-thirds of spending for durables.

Nursing home care

National spending for nursing home care reached $35 billion in 1985, an increase of 10.6 percent from the previous year and a reversal of the deceleration in growth that started in 1982. Data from the Bureau of Labor Statistics show that growth in aggregate hours worked by nonsupervisory personnel in nursing and related care facilities (Standard Industrial Classification 805) slowed from 5.1 percent in 1982 to 3.3 percent in 1984. In 1985, growth accelerated to 4.9 percent. Growth in nursing home employment showed a similar trend.

Part of the growth in spending for nursing home care from 1973 to 1982 was the result of rapid expansion in spending for services in intermediate care facilities for the mentally retarded (ICF/MR's). ICF/MR care is a Medicaid benefit first offered in 1973. In 1985, about $2.9 billion in ICF/MR expenditures (60 percent of the total) were spent

Table 3

National health expenditures, by source of funds and type of expenditure: Calendar years 1980-85

Year and type of expenditure	All sources	Private					Government		
		All private funds	Consumer			Other[1]	Total	Federal	State and local
			Total	Direct	Private insurance				
	Amount in billions								
1985									
National health expenditures	$425.0	$250.2	$238.9	$105.6	$133.3	$11.3	$174.8	$124.4	$50.4
Health services and supplies	409.5	244.3	238.9	105.6	133.3	5.4	165.2	117.2	48.0
Personal health care	371.4	224.0	219.1	105.6	113.5	4.9	147.5	112.6	34.8
Hospital care	166.7	76.9	74.8	15.6	59.3	2.1	89.8	71.6	18.2
Physicians' services	82.8	58.7	58.7	21.8	36.8	0.0	24.1	19.7	4.4
Dentists' services	27.1	26.5	26.5	17.2	9.3	—	0.6	0.3	0.3
Other professional services	12.6	9.0	8.8	6.0	2.8	0.1	3.6	2.8	0.9
Drugs and medical sundries	28.5	25.8	25.8	21.7	4.0	—	2.7	1.4	1.3
Eyeglasses and appliances	7.5	6.1	6.1	5.2	0.9	—	1.5	1.3	0.1
Nursing home care	35.2	18.7	18.4	18.1	0.3	0.3	16.5	9.4	7.1
Other personal health care	11.0	2.3	—	—	—	2.3	8.6	6.0	2.6
Program administration and net cost of private health insurance	26.2	20.4	19.8	—	19.8	0.6	5.8	3.2	2.7
Government public health activities	11.9	—	—	—	—	—	11.9	1.4	10.5
Research and construction of medical facilities	15.4	5.9	—	—	—	5.9	9.6	7.2	2.4
Noncommercial research[2]	7.4	0.4	—	—	—	0.4	7.0	6.4	0.6
Construction	8.1	5.5	—	—	—	5.5	2.6	0.8	1.8
1984									
National health expenditures	390.2	230.7	219.3	97.8	121.5	11.4	159.5	111.7	47.8
Health services and supplies	374.5	224.1	219.3	97.8	121.5	4.9	150.4	105.1	45.3
Personal health care	341.1	207.0	202.7	97.8	104.9	4.3	134.1	100.9	33.2
Hospital care	155.3	72.6	70.6	14.3	56.4	1.9	82.8	65.3	17.5
Physicians' services	75.4	54.2	54.2	20.9	33.3	0.0	21.1	17.0	4.1
Dentists' services	24.6	24.1	24.1	15.9	8.2	—	0.5	0.3	0.3
Other professional services	10.9	7.8	7.7	5.3	2.4	0.1	3.1	2.4	0.8
Drugs and medical sundries	26.5	24.2	24.2	20.6	3.6	—	2.4	1.2	1.2
Eyeglasses and appliances	7.0	5.7	5.7	5.0	0.8	—	1.2	1.1	0.1
Nursing home care	31.9	16.4	16.1	15.8	0.3	0.2	15.5	8.6	6.9
Other personal health care	9.4	2.0	—	—	—	2.0	7.4	5.1	2.3
Program administration and net cost of private health insurance	22.6	17.1	16.6	—	16.6	0.5	5.4	2.9	2.6
Government public health activities	10.9	—	—	—	—	—	10.9	1.4	9.5
Research and construction of medical facilities	15.6	6.6	—	—	—	6.6	9.1	6.5	2.5
Noncommercial research[2]	6.8	0.4	—	—	—	0.4	6.4	5.8	0.6
Construction	8.9	6.2	—	—	—	6.2	2.7	0.7	1.9

See footnotes at end of table.

in nursing homes. Despite the relatively small size of ICF/MR spending, these payments have raised the growth rate for total nursing home spending in almost every year since they began. The rate of growth of ICF/MR spending slowed from 45 percent in 1981 to 17 percent in 1985.

Growth in spending for nursing home care other than in ICF/MR's also slowed considerably in recent years. Part of this slowdown is the result of a deceleration in the growth of input prices paid by nursing homes. The Health Care Financing Administration's National Nursing Home Input Price Index rose 4.3 percent in 1985, the smallest increase since this measure was developed.

Two-fifths of the increase in expenditures for nursing home care other than for ICF/MR's from 1984 to 1985 was attributable to price inflation. A 2-percent increase in the aged population in 1985 accounted for one-fifth of the growth in nursing home spending. The residual can be accounted for by changes in the amounts and mix of nursing home goods and services provided.

Although firm data are not yet available, estimates used in preparation of the national health expenditures statistics show that the average charge per day of care in nonhospital nursing care facilities reached $55 in 1985, more than double the charge per day reported in the 1976-77 National Nursing Home Survey. Separate estimates are not available for skilled, intermediate, or personal levels of care offered by nursing care facilities.

The share of nursing home care financed by public programs declined from 1979 to 1985, from 56 percent to 47 percent. Almost all of that decline was in Medicaid and Medicare shares. (Medicaid accounts for almost 90 percent of public spending for nursing home care.) Reduced utilization of nursing home care by Medicaid and Medicare patients has been occurring. Selective admitting practices of nursing homes in areas with a shortage of nursing home beds are partly responsible for this trend (Feder and Scanlon, 1981). Higher paying private patients may be admitted before Medicaid or Medicare patients are.

Table 3—Continued

National health expenditures, by source of funds and type of expenditure: Calendar years 1980-85

Year and type of expenditure	All sources	Private					Government		
		All private funds	Consumer						
			Total	Direct	Private insurance	Other[1]	Total	Federal	State and local
	Amount in billions								
1983									
National health expenditures	$357.2	$209.7	$198.4	$88.7	$109.7	$11.3	$147.5	$102.7	$44.8
Health services and supplies	341.8	202.8	198.4	88.7	109.7	4.5	138.9	96.9	42.1
Personal health care	314.7	190.6	186.7	88.7	98.0	4.0	124.1	92.9	31.1
Hospital care	146.8	70.0	68.2	13.3	54.9	1.8	76.8	60.4	16.4
Physicians' services	68.4	49.0	48.9	19.3	29.6	0.0	19.5	15.6	3.8
Dentists' services	21.7	21.2	21.2	13.8	7.3	—	0.6	0.3	0.3
Other professional services	9.3	6.6	6.5	4.4	2.1	0.1	2.7	2.0	0.7
Drugs and medical sundries	24.5	22.3	22.3	19.2	3.2	—	2.1	1.1	1.1
Eyeglasses and appliances	6.2	5.2	5.2	4.5	0.7	—	1.0	0.9	0.1
Nursing home care	29.4	14.6	14.4	14.1	0.3	0.2	14.8	8.1	6.7
Other personal health care	8.3	1.8	—	—	—	1.8	6.5	4.5	2.0
Program administration and net cost of private health insurance	17.1	12.2	11.7	—	11.7	0.5	4.9	2.7	2.3
Government public health activities	9.9	—	—	—	—	—	9.9	1.3	8.7
Research and construction of medical facilities	15.4	6.8	—	—	—	6.8	8.6	5.9	2.7
Noncommercial research[2]	6.2	0.4	—	—	—	0.4	5.8	5.2	0.6
Construction	9.2	6.5	—	—	—	6.5	2.8	0.7	2.1
1982									
National health expenditures	323.6	188.4	178.3	79.6	98.7	10.1	135.3	93.2	42.1
Health services and supplies	309.4	182.2	178.3	79.6	98.7	3.9	127.1	87.6	39.5
Personal health care	286.5	173.0	169.5	79.6	89.9	3.5	113.5	83.9	29.5
Hospital care	135.2	63.9	62.4	11.1	51.3	1.5	71.2	55.4	15.9
Physicians' services	61.8	44.9	44.8	18.2	26.6	0.0	16.9	13.4	3.6
Dentists' services	19.5	18.9	18.9	12.3	6.6	—	0.6	0.3	0.3
Other professional services	8.0	5.8	5.7	3.9	1.8	0.1	2.2	1.6	0.6
Drugs and medical sundries	22.1	20.2	20.2	17.4	2.8	—	2.0	1.0	1.0
Eyeglasses and appliances	5.8	5.0	5.0	4.4	0.6	—	0.8	0.7	0.1
Nursing home care	26.7	12.7	12.5	12.2	0.3	0.2	14.0	7.7	6.4
Other personal health care	7.4	1.7	—	—	—	1.7	5.7	3.9	1.8
Program administration and net cost of private health insurance	13.5	9.2	8.7	—	8.7	0.4	4.3	2.4	1.9
Government public health activities	9.3	—	—	—	—	—	9.3	1.2	8.1
Research and construction of medical facilities	14.3	6.1	—	—	—	6.1	8.2	5.6	2.5
Noncommercial research[2]	5.9	0.3	—	—	—	0.3	5.5	5.0	0.6
Construction	8.4	5.8	—	—	—	5.8	2.6	0.6	2.0

See footnotes at end of table.

The shortage of beds may be induced by some State governments in order to minimize Medicaid expenditures. Tactics used include tightening certificate-of-need requirements and keeping reimbursement rates low (Weissert et al., 1983). Potential investors in the nursing home business may be discouraged by the low profitability of the industry because of these reimbursement policies.

Other personal health care

Spending for other personal health care amounted to $11 billion in 1985. A majority of these services are financed by Federal funds. Care provided in federally operated clinics run by the Department of Defense and miscellaneous services provided through the Medicaid and Medicare programs are included in this category. Expenditures for grants to community health centers, State and locally funded school health programs, and privately funded industrial onsite health services are also included.

Other health services and supplies

The cost of operating third-party programs in 1985 rose 16.1 percent to $26 billion. This estimate includes $5.8 billion in administrative expenses for those public programs from which data on administrative expenses are available. A small amount estimated to comprise the fundraising and administrative expenses of philanthropic organizations is also included. The largest part of this category is the net cost of private health insurance (the difference between earned premiums and incurred claims). Estimated at $20 billion for 1985, net cost reflects administrative and other operating expenses; additions to loss reserves; taxes; and profits or losses of Blue Cross and Blue Shield plans, mutual and stock carriers, and prepaid and self-insured health plans.

Table 3—Continued

National health expenditures, by source of funds and type of expenditure: Calendar years 1980-85

Year and type of expenditure	All sources	Private					Government		
		All private funds	Consumer						
			Total	Direct	Private insurance	Other[1]	Total	Federal	State and local
	Amount in billions								
1981									
National health expenditures	$287.0	$165.8	$157.0	$72.6	$84.4	$8.7	$121.2	$83.3	$37.9
Health services and supplies	273.8	160.6	157.0	72.6	84.4	3.6	113.2	77.9	35.3
Personal health care	254.7	154.2	151.0	72.6	78.4	3.2	100.5	74.1	26.3
Hospital care	119.1	56.6	55.2	10.1	45.1	1.4	62.5	48.5	14.0
Physicians' services	54.8	39.7	39.7	16.9	22.8	0.0	15.0	11.7	3.3
Dentists' services	17.3	16.6	16.6	10.9	5.8	—	0.7	0.4	0.3
Other professional services	6.8	5.1	5.0	3.6	1.5	0.1	1.7	1.3	0.5
Drugs and medical sundries	20.7	18.8	18.8	16.3	2.5	—	1.9	0.9	0.9
Eyeglasses and appliances	5.3	4.7	4.7	4.2	0.5	—	0.7	0.6	0.1
Nursing home care	23.9	11.0	10.9	10.7	0.2	0.2	12.8	7.2	5.7
Other personal health care	6.8	1.6	—	—	—	1.6	5.2	3.6	1.6
Program administration and net cost of private health insurance	10.6	6.4	6.0	—	6.0	0.4	4.2	2.5	1.7
Government public health activities	8.5	—	—	—	—	—	8.5	1.3	7.2
Research and construction of medical facilities	13.2	5.2	—	—	—	5.2	8.0	5.4	2.6
Noncommercial research[2]	5.6	0.3	—	—	—	0.3	5.3	4.8	0.5
Construction	7.6	4.8	—	—	—	4.8	2.7	0.7	2.1
1980									
National health expenditures	248.1	142.9	135.6	63.0	72.6	7.3	105.2	71.0	34.2
Health services and supplies	236.2	138.7	135.6	63.0	72.6	3.0	97.5	65.8	31.7
Personal health care	219.7	133.2	130.5	63.0	67.5	2.7	86.5	62.5	24.0
Hospital care	101.6	47.7	46.6	7.9	38.7	1.1	53.9	41.1	12.8
Physicians' services	46.8	34.2	34.2	14.2	20.0	0.0	12.6	9.6	3.0
Dentists' services	15.4	14.8	14.8	10.1	4.7	—	0.6	0.3	0.3
Other professional services	5.7	4.2	4.2	2.8	1.4	0.1	1.4	1.0	0.4
Drugs and medical sundries	18.8	17.1	17.1	15.0	2.2	—	1.6	0.8	0.8
Eyeglasses and appliances	5.1	4.5	4.5	4.1	0.4	—	0.6	0.5	0.1
Nursing home care	20.4	9.2	9.1	8.9	0.2	0.1	11.2	6.0	5.2
Other personal health care	5.9	1.4	—	—	—	1.4	4.5	3.1	1.4
Program administration and net cost of private health insurance	9.2	5.4	5.1	—	5.1	0.3	3.8	2.0	1.7
Government public health activities	7.3	—	—	—	—	—	7.3	1.3	6.0
Research and construction of medical facilities	11.9	4.3	—	—	—	4.3	7.7	5.2	2.4
Noncommercial research[2]	5.4	0.3	—	—	—	0.3	5.1	4.7	0.5
Construction	6.5	4.0	—	—	—	4.0	2.5	0.6	2.0

[1]Spending by philanthropic organizations, industrial inplant health services, and privately financed construction.
[2]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but they are included in the expenditure class in which the product falls.

NOTE: 0.0 denotes less than $50 million.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Public health activities of various levels of government cost $12 billion in 1985. Public health activities are functions carried out by Federal, State, and local governments to support community health, in contrast to care delivered to individuals. Federal expenditures of $1.4 billion included the services of the Centers for Disease Control and the Food and Drug Administration, as well as grants to States. State and local expenditures included funds spent by State and local health departments.

Other national health expenditures

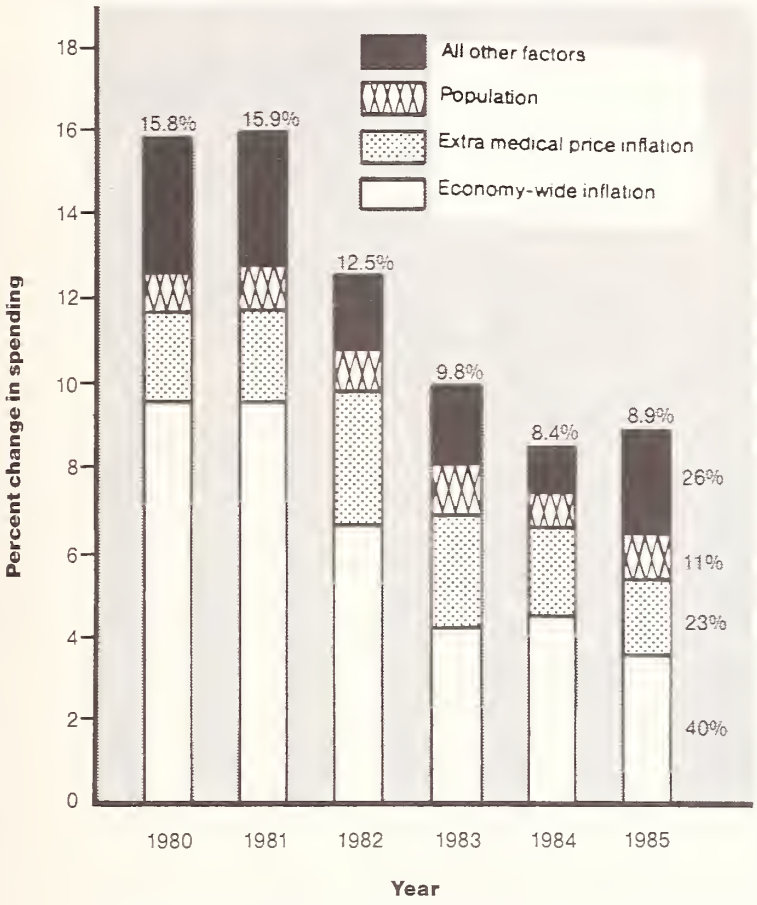
National health expenditures devoted to nonprofit research and to construction of medical facilities were $15 billion in 1985. This amount is equal to 4 percent of total health spending.

Expenditures for noncommercial health care research and development were $7.4 billion in 1985. The Federal Government financed by far the largest amount for research, with funds totaling $6.4 billion, most of which was spent by the National Institutes of Health. Expenditures by State and local governments, exclusive of Federal grants, were $638 million. Private philanthropy funded an even smaller amount.

Of the $8.1 billion spent on construction of medical facilities in 1985, 32 percent was funded from public sources. Grants from philanthropic organizations funded 4 percent, and the remainder came from internal funds or the private capital market.

Figure 3

Factors affecting the growth of personal health care expenditures: Calendar years 1980-85



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

During the last 5 years, spending for personal health care has grown at diminished rates. In 1985, two-thirds of the growth was attributable to price inflation and another one-quarter to changes in use per capita.

Financing health care

Health care may be financed directly through out-of-pocket expenditures or indirectly through third parties. Third parties may be either private, as in private health insurance, or public, as in the Medicaid and Medicare programs. A historical trend in health care financing has been the decline in the direct financing of care by individuals. This trend has created an arena for rapidly increasing health care costs because the beneficiary of care is insulated from the payment (and thereby the cost) at the time health care is purchased.

As health care costs reached 10 percent of the GNP, businesses purchasing insurance policies for their employees faced rapidly rising insurance premiums that were eating away at profits. Public programs faced with finite budgets began to take a hard look at health care. Medicare in particular faced the bleak prospect of a depleted hospital insurance trust fund in the near future. In the early 1980's, price increases in health care exceeded those in the general economy by a wide margin. Those increases, coupled with high unemployment and an economy-wide recession, forced businesses and governments to seek alternatives to fee-for-service medicine in order to reduce the spiraling growth of health care costs.

Financers of health care have helped to shape the delivery system. Strong cost containment and cost management decisions have begun to shift the sites of care away from expensive inpatient hospital settings. Incentives for purchasers (e.g., higher coinsurance and deductibles, "cafeteria" benefit plans) and providers of care (e.g., prospective payment, capitation, purchase of providers by insurers) have been implemented in some care sectors to make purchases more prudent.

In the past 10 years, the split between private and public payers in financing personal health care has remained almost constant, with private payers financing 60 percent of all care and public payers 40 percent. However, a definite shift has occurred within the private and public sectors. In the public sector, the Federal government has financed increasing proportions of care, primarily through the Medicare program. Private health insurance's share of payments in the private sector has risen, principally through increased coverage of nonhospital services.

Private health insurance

In 1985, Blue Cross and Blue Shield plans, commercial insurance companies, and prepaid and self-insured plans incurred claims estimated at $113 billion, an amount equal to 31 percent of personal health care expenditures (Table 4). Benefit payments grew by 8.2 percent in 1985. Insurers earned an estimated $133 billion in premiums, 53 percent of all nonpublic spending for health, resulting in a net cost to enrollees of $20 billion.

The size of the private health insurance industry has been growing because of the desire of consumers for reduced risk of high out-of-pocket costs and the preferential tax treatment of premiums. By 1985, 31 percent of expenditures for personal health care were reimbursed by private insurance.

Self-insured plans (health insurance coverage provided by employers who assume all or part of

Table 4

Personal health care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government			Medicare[1]	Medicaid[2]
						Total	Federal	State and local		
					Amount in billions					
1965	$35.9	$18.5	$17.3	$8.7	$0.8	$7.9	$3.6	$4.3	—	—
1966	39.7	19.6	20.0	9.1	0.8	10.1	5.3	4.9	$1.0	$1.5
1967	44.5	19.0	25.5	9.6	0.8	15.1	9.5	5.6	4.5	2.9
1968	50.3	20.7	29.6	10.9	0.9	17.8	11.4	6.4	5.7	3.8
1969	57.1	23.0	34.0	12.9	0.9	20.2	13.2	7.0	6.6	4.4
1970	65.4	26.5	38.9	15.3	1.1	22.4	14.5	7.9	7.1	5.2
1971	72.2	28.1	44.1	17.2	1.3	25.6	16.8	8.8	7.9	6.8
1972	80.5	30.6	49.9	19.0	2.0	28.8	18.9	9.9	8.6	8.2
1973	89.0	33.3	55.7	21.4	2.2	32.1	21.1	11.1	9.6	9.3
1974	101.3	36.2	65.1	25.1	1.5	38.5	25.7	12.8	12.4	10.8
1975	117.1	38.1	79.0	31.2	1.6	46.3	31.4	14.9	15.6	13.5
1976	132.8	42.0	90.8	37.6	1.8	51.4	36.1	15.3	18.4	15.1
1977	149.1	46.4	102.7	43.0	2.0	57.8	40.9	16.8	21.8	16.9
1978	167.4	50.7	116.7	49.1	2.1	65.5	46.3	19.2	24.9	18.8
1979	189.7	55.8	133.8	56.9	2.3	74.6	53.3	21.3	29.3	21.8
1980	219.7	63.0	156.7	67.5	2.7	86.5	62.5	24.0	35.7	25.2
1981	254.7	72.6	182.1	78.4	3.2	100.5	74.1	26.3	43.5	29.0
1982	286.5	79.6	206.9	89.9	3.5	113.5	83.9	29.5	51.1	31.3
1983	314.7	88.7	226.0	98.0	4.0	124.1	92.9	31.1	57.4	33.9
1984	341.1	97.8	243.3	104.9	4.3	134.1	100.9	33.2	62.9	36.3
1985	371.4	105.6	265.8	113.5	4.9	147.5	112.6	34.8	70.5	39.8
					Per capita amount					
1965	$176	$91	$85	$42	$4	$39	$18	$21	—	—
1966	192	95	97	44	4	49	25	24	(3)	(3)
1967	213	91	122	46	4	72	45	27	(3)	(3)
1968	239	98	140	52	4	84	54	30	(3)	(3)
1969	268	108	160	61	4	95	62	33	(3)	(3)
1970	304	123	181	71	5	104	68	37	(3)	(3)
1971	332	129	203	79	6	118	77	41	(3)	(3)
1972	367	140	227	87	9	131	86	45	(3)	(3)
1973	402	150	252	97	10	145	95	50	(3)	(3)
1974	454	162	292	113	7	173	115	57	(3)	(3)
1975	521	169	351	139	7	206	140	66	(3)	(3)
1976	586	185	400	166	8	227	159	67	(3)	(3)
1977	652	203	449	188	9	253	179	74	(3)	(3)
1978	725	220	506	213	9	284	201	83	(3)	(3)
1979	814	240	574	244	10	320	229	91	(3)	(3)
1980	934	268	666	287	11	367	266	102	(3)	(3)
1981	1,071	305	766	330	13	423	312	111	(3)	(3)
1982	1,193	332	861	374	15	472	349	123	(3)	(3)
1983	1,298	366	932	404	16	512	383	128	(3)	(3)
1984	1,394	400	994	429	18	548	412	136	(3)	(3)
1985	1,504	428	1,076	460	20	597	456	141	(3)	(3)
					Percent distribution					
1965	100.0	51.6	48.4	24.2	2.2	22.0	10.1	11.9	—	—
1966	100.0	49.5	50.5	22.9	2.1	25.5	13.2	12.3	2.6	3.7
1967	100.0	42.6	57.4	21.6	1.9	33.9	21.3	12.6	10.2	6.4
1968	100.0	41.2	58.8	21.7	1.8	35.3	22.6	12.7	11.3	7.5
1969	100.0	40.4	59.6	22.7	1.6	35.3	23.1	12.3	11.6	7.7
1970	100.0	40.5	59.5	23.4	1.7	34.3	22.2	12.1	10.9	8.0
1971	100.0	38.9	61.1	23.8	1.8	35.5	23.2	12.3	10.9	9.4
1972	100.0	38.0	62.0	23.6	2.5	35.8	23.5	12.3	10.7	10.2
1973	100.0	37.4	62.6	24.0	2.5	36.1	23.7	12.4	10.8	10.4
1974	100.0	35.7	64.3	24.8	1.5	38.0	25.4	12.6	12.3	10.7
1975	100.0	32.5	67.5	26.7	1.3	39.5	26.8	12.7	13.3	11.6
1976	100.0	31.6	68.4	28.3	1.4	38.7	27.2	11.5	13.9	11.4
1977	100.0	31.1	68.9	28.8	1.3	38.7	27.4	11.3	14.6	11.3
1978	100.0	30.3	69.7	29.3	1.2	39.2	27.7	11.5	14.9	11.2
1979	100.0	29.4	70.6	30.0	1.2	39.3	28.1	11.2	15.5	11.5
1980	100.0	28.7	71.3	30.7	1.2	39.4	28.4	10.9	16.2	11.5
1981	100.0	28.5	71.5	30.8	1.3	39.5	29.1	10.3	17.1	11.4
1982	100.0	27.8	72.2	31.4	1.2	39.6	29.3	10.3	17.8	10.9

See footnotes at end of table.

Table 4—Continued

Personal health care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local	Medicare[1]	Medicaid[2]
1983	100.0	28.2	71.8	31.1	1.3	39.4	29.5	9.9	18.3	10.8
1984	100.0	28.7	71.3	30.7	1.3	39.3	29.6	9.7	18.4	10.7
1985	100.0	28.4	71.6	30.6	1.3	39.7	30.3	9.4	19.0	10.7

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTE: Per capita amounts based on July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

their own insurance risk) have been growing since the latter part of the 1970's. This growth has been stimulated by tax and other financial advantages to employers. Insurance companies have also contributed to this growth by providing administrative and stop-loss services that aid and protect self-insured plans. The prepaid plans category, comprised of health maintenance organizations and single-service plans, has also grown significantly in recent years, but it still remains a small part of overall insurance.

Historically, private health insurance (PHI) has paid significant proportions of hospital and physician expenditures and a very small proportion of nursing home care. In 1985, 36 percent of all hospital services (Table 5) and 45 percent of all physician care (Table 6) was financed through PHI. Only 1 percent of all nursing home expenditures came from this source.

Dental services and purchases of drugs and of eyeglasses and appliances are the growth sectors for insurance, areas where the share financed by PHI has doubled in the last 10 years. For dental services, PHI's share rose from 14 percent in 1975 to 34 percent in 1985; for drugs, from 6 percent to 14 percent; and for eyeglasses and appliances, from 3 to 12 percent. In 1985, insurance paid for 23 percent of other professional services, predominantly for private-duty nursing and other miscellaneous professional services.

Public expenditures

Public expenditures for health grew 9.6 percent in 1985, funding 41 percent of all national health expenditures. Public programs spent $175 billion in 1985, 84 percent for the financing of personal care services. The remainder funded the administration of public programs ($6 billion in 1985), public health activities ($12 billion), research ($7 billion), and construction ($3 billion).

Of all public personal health care expenditures, 61 percent went for financing care in hospitals. In 1985, 54 percent of all hospital care was funded by these programs. Public programs spent $24 billion (16 percent of all public funds) for physicians' services, financing 29 percent of the Nation's physician bill. Public funds covered 47 percent of the Nation's nursing home bill (Table 7). This percentage has been dropping over the last 6 years as the proportion funded by Medicaid has declined. Public programs financed 20 percent of all remaining personal health care services (Table 8).

Health Care Financing Administration programs

In 1985, the Health Care Financing Administration's Medicare and Medicaid programs financed 30 cents of every dollar spent for personal health care in the United States. The two programs expended $110 billion in benefits (Table 9). This figure does not include $538 million spent to purchase Medicare supplementary medical insurance for eligible Medicaid recipients. To eliminate double counting, "buy-in" premiums paid to Medicare for Medicaid eligibles are subtracted when data from the two programs are presented together.

The introduction of these two programs, which accounted for almost three-quarters of all public spending in 1985, has dramatically increased the presence of the Federal Government in the health care market. Currently, the two programs pay 38 percent of all hospital expenditures, 25 percent of all physician expenditures, and 43 percent of all nursing home expenditures.

Medicare—More than $31 million aged and disabled people are enrolled in Medicare. The program spent $71 billion in benefit (personal health care) payments in 1985 for the 21.4 million enrollees who received benefits. Despite PPS and other cost containment measures, growth in Medicare spending for personal health care accelerated in 1985. Spending increased by 12.2 percent from 1984 to 1985, compared with the 9.5-percent growth experienced from 1983 to 1984.

In 1985, Medicare financed 48 percent of the public share of personal health care expenditures and 19 percent of total spending for personal health care. Almost 69 percent of Medicare benefits were for

Table 5

Hospital care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government			Medicare[1]	Medicaid[2]
						Total	Federal	State and local		
					Amount in billions					
1965	$14.0	$2.3	$11.6	$5.7	$0.3	$5.6	$2.4	$3.1	—	—
1966	15.8	2.6	13.2	6.0	0.3	6.9	3.5	3.4	$0.9	$0.6
1967	18.4	1.9	16.4	6.2	0.3	10.0	6.3	3.7	3.1	1.2
1968	21.1	2.3	18.8	7.0	0.4	11.5	7.3	4.1	3.8	1.6
1969	24.2	2.6	21.6	8.2	0.3	13.1	8.5	4.6	4.5	1.8
1970	28.0	3.2	24.8	9.7	0.4	14.7	9.5	5.1	5.1	2.2
1971	31.0	3.1	27.9	10.9	0.5	16.5	10.9	5.6	5.7	2.9
1972	35.2	3.5	31.7	11.8	1.2	18.6	12.4	6.2	6.3	3.4
1973	38.9	3.9	35.0	13.1	1.4	20.6	13.7	6.9	7.1	3.5
1974	45.0	4.9	40.2	15.1	0.6	24.4	16.7	7.7	9.2	3.8
1975	52.4	4.2	48.2	18.8	0.6	28.9	20.1	8.8	11.5	4.8
1976	60.9	5.2	55.7	22.5	0.7	32.5	23.7	8.8	13.6	5.8
1977	68.1	5.4	62.7	25.5	0.7	36.5	27.0	9.6	16.0	6.5
1978	76.2	5.6	70.7	28.6	0.8	41.3	30.4	10.9	18.2	7.1
1979	87.0	6.4	80.6	33.0	0.9	46.6	34.8	11.8	21.2	8.2
1980	101.6	7.9	93.7	38.7	1.1	53.9	41.1	12.8	25.9	9.6
1981	119.1	10.1	109.0	45.1	1.4	62.5	48.5	14.0	31.4	10.9
1982	135.2	11.1	124.1	51.3	1.5	71.2	55.4	15.9	36.8	11.8
1983	146.8	13.3	133.6	54.9	1.8	76.8	60.4	16.4	40.5	12.9
1984	155.3	14.3	141.1	56.4	1.9	82.8	65.3	17.5	44.1	13.8
1985	166.7	15.6	151.2	59.3	2.1	89.8	71.6	18.2	48.5	14.8
					Per capita amount					
1965	$68	$12	$57	$28	$1	$27	$12	$15	—	—
1966	76	13	64	29	2	33	17	16	[3]	[3]
1967	88	9	79	30	1	48	30	18	[3]	[3]
1968	100	11	89	33	2	54	35	20	[3]	[3]
1969	114	12	102	39	2	62	40	21	[3]	[3]
1970	130	15	115	45	2	68	44	24	[3]	[3]
1971	143	14	128	50	2	76	50	26	[3]	[3]
1972	160	16	144	54	6	85	56	28	[3]	[3]
1973	176	18	158	59	6	93	62	31	[3]	[3]
1974	202	22	180	68	3	110	75	35	[3]	[3]
1975	233	19	215	84	2	128	90	39	[3]	[3]
1976	268	23	246	99	3	143	105	39	[3]	[3]
1977	298	24	274	111	3	160	118	42	[3]	[3]
1978	330	24	306	124	3	179	132	47	[3]	[3]
1979	373	27	346	142	4	200	149	51	[3]	[3]
1980	432	34	398	165	5	229	175	55	[3]	[3]
1981	501	42	458	190	6	263	204	59	[3]	[3]
1982	563	46	517	214	6	297	231	66	[3]	[3]
1983	605	55	551	227	7	317	249	68	[3]	[3]
1984	635	58	577	230	8	338	267	71	[3]	[3]
1985	675	63	612	240	9	364	290	74	[3]	[3]
					Percent distribution					
1965	100.0	16.8	83.2	41.1	2.2	39.9	17.4	22.5	—	—
1966	100.0	16.4	83.6	37.7	2.0	43.8	22.4	21.4	5.5	3.8
1967	100.0	10.6	89.4	33.5	1.6	54.3	34.2	20.1	17.1	6.6
1968	100.0	10.9	89.1	33.2	1.7	54.2	34.7	19.5	17.9	7.4
1969	100.0	10.7	89.3	33.9	1.3	54.0	35.2	18.8	18.7	7.5
1970	100.0	11.4	88.6	34.6	1.6	52.4	34.1	18.4	18.2	8.0
1971	100.0	10.1	89.9	35.0	1.7	53.1	35.0	18.1	18.5	9.5
1972	100.0	10.0	90.0	33.7	3.5	52.8	35.2	17.6	18.0	9.6
1973	100.0	10.1	89.9	33.5	3.5	52.9	35.3	17.6	18.2	9.0
1974	100.0	10.8	89.2	33.6	1.4	54.2	37.1	17.1	20.4	8.3
1975	100.0	7.9	92.1	35.9	1.1	55.1	38.4	16.7	21.9	9.1
1976	100.0	8.5	91.5	37.0	1.2	53.4	39.0	14.4	22.4	9.5
1977	100.0	8.0	92.0	37.4	1.1	53.6	39.6	14.0	23.5	9.5
1978	100.0	7.3	92.7	37.6	1.0	54.1	39.8	14.3	23.8	9.4
1979	100.0	7.4	92.6	38.0	1.0	53.6	40.1	13.6	24.4	9.5
1980	100.0	7.8	92.2	38.1	1.1	53.1	40.4	12.6	25.5	9.4
1981	100.0	8.5	91.5	37.9	1.2	52.5	40.7	11.7	26.4	9.1
1982	100.0	8.2	91.8	38.0	1.1	52.7	41.0	11.7	27.3	8.7

See footnotes at end of table.

Table 5—Continued

Hospital care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local	Medicare[1]	Medicaid[2]
1983	100.0	9.0	91.0	37.4	1.2	52.3	41.2	11.2	27.6	8.8
1984	100.0	9.2	90.8	36.3	1.3	53.3	42.0	11.3	28.4	8.9
1985	100.0	9.3	90.7	35.6	1.3	53.8	43.0	10.9	29.1	8.9

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTE: Per capita amounts based on July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Table 6

Physician care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local	Medicare[1]	Medicaid[2]
					Amount in billions					
1965	$8.5	$5.2	$3.3	$2.7	$0.0	$0.6	$0.2	$0.4	—	—
1966	9.2	5.5	3.7	2.8	0.0	0.8	0.3	0.5	$0.1	$0.1
1967	10.1	5.1	5.0	3.0	0.0	2.0	1.4	0.7	1.1	0.3
1968	11.1	5.2	5.9	3.4	0.0	2.5	1.8	0.7	1.4	0.5
1969	12.6	5.8	6.8	4.0	0.0	2.8	2.0	0.7	1.6	0.6
1970	14.3	6.5	7.8	4.8	0.0	3.0	2.1	0.9	1.6	0.7
1971	15.9	7.1	8.8	5.3	0.0	3.5	2.5	1.0	1.8	0.9
1972	17.2	7.2	10.0	6.0	0.0	3.9	2.8	1.2	2.0	1.1
1973	19.1	7.8	11.3	6.9	0.0	4.4	3.1	1.4	2.1	1.4
1974	21.2	7.7	13.5	8.1	0.0	5.4	3.8	1.6	2.7	1.5
1975	24.9	8.5	16.4	9.9	0.0	6.6	4.7	1.9	3.4	1.9
1976	27.6	9.0	18.5	11.4	0.0	7.1	5.2	1.9	3.9	1.8
1977	31.9	10.8	21.1	13.0	0.0	8.1	6.0	2.1	4.6	1.8
1978	35.8	11.5	24.3	15.0	0.0	9.3	6.9	2.4	5.4	2.0
1979	40.2	12.4	27.8	17.1	0.0	10.7	8.1	2.6	6.5	2.2
1980	46.8	14.2	32.6	20.0	0.0	12.6	9.6	3.0	7.9	2.4
1981	54.8	16.9	37.9	22.8	0.0	15.0	11.7	3.3	9.7	2.8
1982	61.8	18.2	43.6	26.6	0.0	16.9	13.4	3.6	11.4	2.8
1983	68.4	19.3	49.1	29.6	0.0	19.5	15.6	3.8	13.4	2.9
1984	75.4	20.9	54.4	33.3	0.0	21.1	17.0	4.1	14.7	3.1
1985	82.8	21.8	61.0	36.8	0.0	24.1	19.7	4.4	17.1	3.4
					Per capita amount					
1965	$42	$26	$16	$13	$0	$3	$1	$2	—	—
1966	44	27	18	14	0	4	2	3	(3)	(3)
1967	49	24	24	14	0	10	7	3	(3)	(3)
1968	53	25	28	16	0	12	8	4	(3)	(3)
1969	59	27	32	19	0	13	10	3	(3)	(3)
1970	67	30	36	22	0	14	10	4	(3)	(3)
1971	73	33	40	24	0	16	11	5	(3)	(3)
1972	78	33	45	27	0	18	13	5	(3)	(3)
1973	86	35	51	31	0	20	14	6	(3)	(3)
1974	95	35	61	37	0	24	17	7	(3)	(3)
1975	111	38	73	44	0	29	21	8	(3)	(3)
1976	122	40	82	50	0	31	23	9	(3)	(3)
1977	139	47	92	57	0	35	26	9	(3)	(3)
1978	155	50	105	65	0	40	30	10	(3)	(3)
1979	173	53	119	73	0	46	35	11	(3)	(3)
1980	199	61	139	85	0	54	41	13	(3)	(3)
1981	230	71	159	96	0	63	49	14	(3)	(3)
1982	257	76	182	111	0	71	56	15	(3)	(3)

See footnotes at end of table.

Table 6—Continued

Physician care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties						Medicare[1]	Medicaid[2]
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local		
			Amount in billions							
1983	282	80	202	122	0	80	64	16	(3)	(3)
1984	308	85	223	136	0	86	70	17	(3)	(3)
1985	335	88	247	149	0	98	80	18	(3)	(3)
			Percent distribution							
1965	100.0	61.6	38.4	31.4	0.1	6.9	1.8	5.1	—	—
1966	100.0	60.0	40.0	30.7	0.1	9.3	3.4	5.9	1.3	1.6
1967	100.0	50.3	49.7	29.4	0.1	20.2	13.6	6.6	11.0	3.1
1968	100.0	46.9	53.1	30.5	0.1	22.5	15.8	6.7	12.6	4.2
1969	100.0	46.2	53.8	31.8	0.1	21.9	16.2	5.8	12.7	4.4
1970	100.0	45.4	54.6	33.6	0.1	20.9	14.9	6.0	11.3	4.8
1971	100.0	44.8	55.2	33.4	0.1	21.7	15.5	6.3	11.5	5.6
1972	100.0	41.9	58.1	35.1	0.1	22.9	16.2	6.7	11.6	6.5
1973	100.0	40.7	59.3	36.0	0.1	23.3	16.1	7.1	11.1	7.1
1974	100.0	36.3	63.7	38.4	0.1	25.2	17.8	7.4	12.6	7.2
1975	100.0	34.1	65.9	39.5	0.1	26.3	18.8	7.6	13.5	7.5
1976	100.0	32.7	67.3	41.5	0.1	25.7	18.8	7.0	14.0	6.4
1977	100.0	33.8	66.2	40.8	0.1	25.4	18.7	6.7	14.4	5.8
1978	100.0	32.1	67.9	41.9	0.1	25.9	19.3	6.6	15.2	5.7
1979	100.0	30.8	69.2	42.4	0.0	26.7	20.2	6.6	16.2	5.4
1980	100.0	30.4	69.6	42.6	0.1	26.9	20.6	6.3	16.9	5.2
1981	100.0	30.9	69.1	41.6	0.1	27.4	21.4	6.1	17.8	5.1
1982	100.0	29.4	70.6	43.1	0.1	27.4	21.7	5.7	18.4	4.5
1983	100.0	28.3	71.7	43.2	0.1	28.4	22.8	5.6	19.6	4.3
1984	100.0	27.7	72.3	44.1	0.1	28.1	22.6	5.5	19.4	4.1
1985	100.0	26.3	73.7	44.5	0.1	29.1	23.8	5.3	20.6	4.1

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTES: 0.0 denotes less than $50 million for aggregate amounts, and 0 denotes less than $.50 for per capita amounts. Per capita amounts are based on July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Table 7

Nursing home care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties						Medicare[1]	Medicaid[2]
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local		
			Amount in billions							
1965	$2.1	$1.3	$0.7	$0.0	$0.0	$0.7	$0.5	$0.3	—	—
1966	2.4	1.4	1.0	0.0	0.0	0.9	0.5	0.4	$0.0	$0.5
1967	2.8	1.4	1.4	0.0	0.0	1.4	0.8	0.6	0.2	0.9
1968	3.4	1.6	1.8	0.0	0.0	1.8	1.1	0.7	0.4	1.1
1969	3.8	1.7	2.1	0.0	0.0	2.0	1.2	0.8	0.3	1.2
1970	4.7	2.4	2.3	0.0	0.0	2.3	1.3	0.9	0.3	1.4
1971	5.6	2.8	2.9	0.0	0.0	2.8	1.7	1.1	0.2	1.9
1972	6.5	3.4	3.1	0.0	0.0	3.0	1.7	1.4	0.2	2.6
1973	7.2	3.5	3.7	0.0	0.1	3.6	2.0	1.6	0.2	3.1
1974	8.5	3.8	4.7	0.1	0.1	4.6	2.6	2.0	0.2	3.9
1975	10.1	4.3	5.8	0.1	0.1	5.6	3.2	2.5	0.3	4.8
1976	11.3	4.9	6.4	0.1	0.1	6.3	3.6	2.7	0.3	5.4
1977	13.0	5.7	7.4	0.1	0.1	7.2	4.1	3.1	0.4	6.2
1978	15.1	6.6	8.5	0.1	0.1	8.3	4.6	3.7	0.3	7.1
1979	17.4	7.4	10.0	0.1	0.1	9.7	5.4	4.3	0.4	8.5
1980	20.4	8.9	11.5	0.2	0.1	11.2	6.0	5.2	0.4	9.8

See footnotes at end of table.

Table 7

Physician care expenditures aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government			Medicare[1]	Medicaid[2]
						Total	Federal	State and local		
1981	23.9	10.7	13.2	0.2	0.2	12.8	7.2	5.7	0.4	11.2
1982	26.7	12.2	14.5	0.3	0.2	14.0	7.7	6.4	0.5	12.3
1983	29.4	14.1	15.3	0.3	0.2	14.8	8.1	6.7	0.5	13.0
1984	31.9	15.8	16.0	0.3	0.2	15.5	8.6	6.9	0.5	13.7
1985	35.2	18.1	17.1	0.3	0.3	16.5	9.4	7.1	0.6	14.7
					Per capita amount					
1965	$10	$7	$4	$0	$0	$3	$2	$1	—	—
1966	11	7	5	0	0	5	3	2	[3]	[3]
1967	13	7	7	0	0	7	4	3	[3]	[3]
1968	16	7	9	0	0	8	5	3	[3]	[3]
1969	18	8	10	0	0	10	6	4	[3]	[3]
1970	22	11	11	0	0	11	6	4	[3]	[3]
1971	26	13	13	0	0	13	8	5	[3]	[3]
1972	30	16	14	0	0	14	8	6	[3]	[3]
1973	32	16	17	0	0	16	9	7	[3]	[3]
1974	38	17	21	0	0	21	12	9	[3]	[3]
1975	45	19	26	0	0	25	14	11	[3]	[3]
1976	50	22	28	0	0	28	16	12	[3]	[3]
1977	57	25	32	0	0	32	18	14	[3]	[3]
1978	65	29	37	1	0	36	20	16	[3]	[3]
1979	75	32	43	1	0	42	23	18	[3]	[3]
1980	87	38	49	1	1	48	26	22	[3]	[3]
1981	100	45	55	1	1	54	30	24	[3]	[3]
1982	111	51	60	1	1	58	32	27	[3]	[3]
1983	121	58	63	1	1	61	33	28	[3]	[3]
1984	130	65	66	1	1	63	35	28	[3]	[3]
1985	143	73	69	1	1	67	38	29	[3]	[3]
					Percent distribution					
1965	100.0	64.5	35.5	0.1	1.0	34.3	22.2	12.1	—	—
1966	100.0	58.7	41.3	0.1	0.9	40.3	22.5	17.8	1.1	20.7
1967	100.0	50.0	50.0	0.3	0.8	49.0	28.1	20.8	7.6	32.7
1968	100.0	46.4	53.6	0.2	0.7	52.7	31.9	20.8	11.7	33.6
1969	100.0	45.5	54.5	0.3	0.7	53.5	32.0	21.5	8.6	32.4
1970	100.0	50.3	49.7	0.4	0.7	48.6	28.6	20.0	5.6	30.3
1971	100.0	48.8	51.2	0.4	0.7	50.1	29.8	20.3	3.2	34.2
1972	100.0	52.4	47.6	0.4	0.7	46.5	25.5	21.0	2.6	39.5
1973	100.0	48.3	51.7	0.5	0.7	50.4	28.4	22.0	2.7	42.9
1974	100.0	44.8	55.2	0.7	0.6	53.9	30.5	23.4	2.9	45.9
1975	100.0	42.7	57.3	0.7	0.6	56.0	31.4	24.6	2.9	47.9
1976	100.0	43.3	56.7	0.8	0.6	55.3	31.4	23.8	2.9	47.3
1977	100.0	43.3	56.7	0.8	0.6	55.2	31.3	24.0	2.8	47.3
1978	100.0	43.8	56.2	0.8	0.6	54.8	30.4	24.4	2.3	47.3
1979	100.0	42.7	57.3	0.8	0.6	55.9	31.2	24.7	2.1	48.6
1980	100.0	43.6	56.4	0.9	0.6	54.9	29.6	25.3	1.9	48.0
1981	100.0	44.7	55.3	0.9	0.6	53.8	30.0	23.8	1.8	47.1
1982	100.0	45.8	54.2	1.0	0.7	52.6	28.7	23.9	1.8	46.2
1983	100.0	48.0	52.0	0.9	0.7	50.4	27.5	22.9	1.8	44.4
1984	100.0	49.7	50.3	0.9	0.7	48.7	27.0	21.8	1.7	43.1
1985	100.0	51.4	48.6	1.0	0.7	46.9	26.8	20.2	1.7	41.8

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTES: 0.0 denotes less than $50 million for aggregate amounts, and 0 denotes less than $.50 for per capita amounts. Per capita amounts are based on July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Table 8

Other personal health care expenditures[1] aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government			Medicare[2]	Medicaid[3]
						Total	Federal	State and local		
					Amount in billions					
1965	$11.3	$9.6	$1.7	$0.3	$0.4	$1.0	$0.6	$0.4	—	—
1966	12.4	10.1	2.2	0.3	0.5	1.4	0.9	0.5	$0.0	$0.2
1967	13.2	10.5	2.7	0.5	0.5	1.7	1.0	0.7	0.1	0.4
1968	14.7	11.6	3.0	0.5	0.5	2.0	1.2	0.8	0.1	0.6
1969	16.4	12.9	3.5	0.7	0.6	2.3	1.4	0.9	0.1	0.7
1970	18.4	14.4	3.9	0.8	0.6	2.5	1.5	1.0	0.1	0.9
1971	19.6	15.1	4.5	1.0	0.7	2.8	1.8	1.1	0.1	1.0
1972	21.6	16.5	5.1	1.1	0.7	3.3	2.1	1.2	0.1	1.2
1973	23.8	18.1	5.7	1.4	0.8	3.5	2.2	1.3	0.2	1.3
1974	26.5	19.7	6.7	1.8	0.8	4.1	2.6	1.5	0.3	1.6
1975	29.7	21.1	8.6	2.5	0.9	5.2	3.4	1.8	0.4	2.1
1976	33.1	22.9	10.2	3.6	1.0	5.6	3.7	1.9	0.6	2.2
1977	36.1	24.6	11.5	4.4	1.1	6.0	3.9	2.0	0.8	2.4
1978	40.2	27.0	13.2	5.3	1.2	6.7	4.5	2.3	1.0	2.5
1979	45.0	29.6	15.4	6.6	1.3	7.5	4.9	2.6	1.2	2.9
1980	50.9	32.0	18.8	8.6	1.5	8.7	5.7	3.0	1.5	3.4
1981	57.0	34.9	22.0	10.2	1.6	10.1	6.7	3.4	1.9	4.1
1982	62.8	38.1	24.7	11.7	1.8	11.3	7.5	3.7	2.4	4.4
1983	70.1	42.0	28.1	13.2	1.9	13.0	8.8	4.2	3.0	5.1
1984	78.5	46.8	31.7	14.9	2.1	14.7	10.0	4.6	3.6	5.7
1985	86.7	50.2	36.5	17.0	2.4	17.0	11.9	5.2	4.4	6.8
					Per capita amount					
1965	$56	$47	$8	$1	$2	$5	$3	$2	—	—
1966	60	49	11	2	2	7	4	3	(4)	(4)
1967	63	50	13	2	2	8	5	3	(4)	(4)
1968	70	55	14	2	3	10	6	4	(4)	(4)
1969	77	60	17	3	3	11	6	4	(4)	(4)
1970	85	67	18	4	3	12	7	5	(4)	(4)
1971	90	69	21	4	3	13	8	5	(4)	(4)
1972	99	75	23	5	3	15	10	5	(4)	(4)
1973	108	82	26	6	3	16	10	6	(4)	(4)
1974	119	89	30	8	4	18	12	7	(4)	(4)
1975	132	94	38	11	4	23	15	8	(4)	(4)
1976	146	101	45	16	5	25	16	8	(4)	(4)
1977	158	108	50	19	5	26	17	9	(4)	(4)
1978	174	117	57	23	5	29	19	10	(4)	(4)
1979	193	127	66	29	6	32	21	11	(4)	(4)
1980	216	136	80	37	6	37	24	13	(4)	(4)
1981	240	147	93	43	7	43	28	14	(4)	(4)
1982	262	159	103	49	7	47	31	16	(4)	(4)
1983	289	173	116	55	8	54	36	17	(4)	(4)
1984	321	191	130	61	9	60	41	19	(4)	(4)
1985	351	203	148	69	10	69	48	21	(4)	(4)
					Percent distribution					
1965	100.0	84.7	15.3	2.3	4.0	9.1	5.1	3.9	—	—
1966	100.0	82.1	17.9	2.6	3.8	11.5	7.1	4.4	0.1	1.8
1967	100.0	79.7	20.3	3.7	3.8	12.8	7.8	4.9	0.6	3.3
1968	100.0	79.2	20.8	3.5	3.6	13.7	8.2	5.5	0.8	4.3
1969	100.0	78.5	21.5	4.2	3.5	13.9	8.4	5.5	0.8	4.5
1970	100.0	78.6	21.4	4.4	3.3	13.7	8.3	5.4	0.7	4.7
1971	100.0	76.9	23.1	4.9	3.6	14.5	9.0	5.6	0.7	5.3
1972	100.0	76.3	23.7	5.3	3.4	15.1	9.8	5.4	0.7	5.3
1973	100.0	76.2	23.8	5.9	3.2	14.7	9.4	5.3	0.8	5.6
1974	100.0	74.6	25.4	6.8	3.1	15.5	10.0	5.6	1.1	6.1
1975	100.0	71.1	28.9	8.4	3.1	17.4	11.5	5.9	1.5	6.9
1976	100.0	69.3	30.7	10.8	3.1	16.8	11.1	5.7	1.8	6.8
1977	100.0	68.1	31.9	12.2	3.1	16.6	10.9	5.7	2.2	6.5
1978	100.0	67.1	32.9	13.2	3.0	16.7	11.1	5.7	2.5	6.2
1979	100.0	65.7	34.3	14.8	2.9	16.6	10.9	5.7	2.7	6.4
1980	100.0	63.0	37.0	17.0	2.9	17.2	11.2	5.9	2.9	6.7

See footnotes at end of table.

Table 8—Continued

Other personal health care expenditures[1] aggregate, per capita, and percent distribution, by source of funds: Calendar years 1965-85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government			Medicare[2]	Medicaid[3]
						Total	Federal	State and local		
1981	100.0	61.4	38.6	18.0	2.9	17.8	11.8	6.0	3.3	7.1
1982	100.0	60.6	39.4	18.6	2.8	17.9	11.9	6.0	3.8	7.0
1983	100.0	59.9	40.1	18.9	2.7	18.5	12.6	6.0	4.3	7.2
1984	100.0	59.6	40.4	19.0	2.7	18.7	12.8	5.9	4.6	7.3
1985	100.0	57.9	42.1	19.6	2.8	19.7	13.7	6.0	5.0	7.9

[1]Personal health care expenditures other than those for hospital care, physicians' services, and nursing home care.
[2]Subset of Federal funds.
[3]Subset of Federal and State and local funds.
[4]Calculation of per capita estimates is inappropriate.

NOTE: Per capita amounts are based on July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Table 9

Personal health care expenditures by Medicare and Medicaid: Calendar years 1965-85

Year	Personal health care expenditures			Population			Medicare financing			
	Medicare and Medicaid[1]	Medicare	Medicaid	Medicare[2]		Medicaid recipients[5]	Inpatient hospital deductible[6]	Supplementary medical insurance monthly premium[7]	Annual maximum taxable earnings	Contribution rate[8]
				Enrollees[3]	Users[4]					
	Amount in billions			Number in millions			Amount in dollars			Percent
1966	$2.5	$1.0	$1.5	19.1	3.7	NA	$40	$3.00	$6,600	0.35
1967	7.4	4.5	2.9	19.5	7.2	NA	40	3.00	6,600	0.50
1968	9.4	5.7	3.8	19.8	7.9	NA	40	4.00	7,800	0.60
1969	10.9	6.6	4.4	20.1	8.6	NA	44	4.00	7,800	0.60
1970	12.2	7.1	5.2	20.5	NA	NA	52	5.30	7,800	0.60
1971	14.5	7.9	6.8	20.9	9.4	NA	60	5.60	7,800	0.60
1972	16.7	8.6	8.2	21.3	10.0	17.6	68	5.80	9,000	0.60
1973	18.7	9.6	9.3	23.5	10.2	19.6	72	[9]6.30	10,800	1.00
1974	23.0	12.4	10.8	24.2	11.8	21.5	84	6.70	13,200	0.90
1975	28.9	15.6	13.5	25.0	13.0	22.0	92	6.70	14,100	0.90
1976	33.3	18.4	15.1	25.7	14.1	22.8	104	7.20	15,300	0.90
1977	38.4	21.8	16.9	26.5	14.9	22.8	124	7.70	16,500	0.90
1978	43.5	24.9	18.8	27.2	15.9	22.0	144	8.20	17,700	1.00
1979	50.8	29.3	21.8	27.9	16.9	21.5	160	8.70	22,900	1.05
1980	60.6	35.7	25.2	28.5	18.0	21.6	180	9.60	25,900	1.05
1981	72.1	43.5	29.0	29.0	18.9	22.0	204	11.00	29,700	1.30
1982	82.0	51.1	31.3	29.5	18.8	21.6	260	12.20	32,400	1.30
1983	91.0	57.4	33.9	30.0	19.7	21.6	304	12.20	35,700	1.30
1984	98.7	62.9	36.3	30.5	[10]20.7	21.6	356	14.60	37,800	[11]1.30
1985	109.7	70.5	39.8	31.1	[10]21.4	21.8	400	15.50	39,600	[11]1.35
1986	NA	NA	NA	NA	NA	NA	492	15.50	42,000	[11]1.45

[1]Excludes "buy-in" premiums paid by Medicaid for supplementary medical insurance coverage of aged and disabled Medicaid recipients eligible for coverage.
[2]Hospital insurance and/or supplementary medical insurance.
[3]Enrollees as of July 1 of specified year.
[4]Users during calendar year. Data through 1973 reflect aged users only. Data for 1974 and later include aged and disabled users.
[5]Unduplicated count of Medicaid recipients during fiscal year.
[6]As of January of specified year with the exception of 1966, for which July data are used.
[7]As of July for 1966-83 and as of January for 1984-86.
[8]Employer and employee (each) and self-employed people through 1983.
[9]Monthly premium for July and August 1973 was reduced to $5.80 and $6.10, respectively, by the Cost of Living Council.
[10]Estimated.
[11]Self-employed people pay double this rate, the equivalent of both the employer and the employee share.

NOTE: NA denotes data not available.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

hospital care; another 24 percent were paid for physicians' services.

Medicare, a Federal insurance program, was originally designed to protect the elderly from the high cost of health care. In addition to people 65 years of age or over, Medicare currently covers permanently disabled workers and their dependents eligible for old age, survivors, and disability insurance benefits and people with end stage renal disease.

Medicare has two parts, each with its own trust fund. The hospital insurance (HI) program pays for inpatient hospital services, posthospital skilled nursing services, home health services, and hospice care. The supplementary medical insurance (SMI) program covers physicians' services, outpatient hospital services and therapy, and a few other services.

Unlike other Federal health programs, Medicare is not financed solely by general revenue (appropriations from general tax receipts). In 1985, 92 percent of the income for the HI program (Table 10) came from a 1.35-percent payroll tax levied on employers and on employees for the first $39,600 of wages. (Self-employed people were required to contribute 2.7 percent, the equivalent of both the employer's and the employee's share of the HI tax.) Payroll contributions to the HI program increased 12.4 percent in fiscal year 1985, and HI benefit payments increased 15.3 percent.

The SMI program was financed by monthly premium payments of $15.50 per enrollee and by general revenue. The general revenue share of SMI receipts has grown significantly, from about 50 percent in 1971 to 73 percent in 1985. Through calendar year 1983, SMI premiums could not increase more than the increase in monthly cash retirement and survivors' benefits, requiring a proportionately greater amount of general tax revenue to maintain the trust fund. During 1984-88, premiums are established so as to cover 25 percent of the costs incurred by aged beneficiaries.

Efforts to curb rapidly growing Medicare expenditures resulted in changes in reimbursement policies in 1982 and 1983. Prospective payment for Medicare patients through diagnosis-related groups (DRG's) was implemented beginning in October 1983. The aim of PPS is to encourage hospitals and attending physicians to consider the economic consequences of prescribed courses of treatment, a facet of health care from which they often were insulated under cost-based reimbursement practices.

Data from the American Hospital Association indicate that PPS is having an effect on utilization among the aged population. After more than a decade of increases in annual utilization of inpatient hospital services, community hospital admissions and total days of care for people aged 65 years or over decreased in 1984 and again in 1985. Since 1983, the annual number of patient days for the aged population has declined 16 percent. However, Medicare expenditures have continued to rise faster than overall hospital spending despite decreases in utilization.

There are allegations of some adverse consequences of PPS: Medicare patients discharged "quicker and sicker," longer backlogs of patients waiting for posthospital care, and a reduction in acceptance of Medicare patients by nursing homes (Guterman, 1986). The major provision for monitoring access and quality of care under PPS is the peer review organization (PRO) program. State PRO's, operating under Federal contracts, are congressionally mandated to monitor hospitals' patient records to assure the necessity of inpatient care and the appropriateness of the treatment setting. PRO's have been directed to reemphasize quality of care and will soon be empowered to deny payment for substandard care.

When Medicare began in 1966, 9.4 percent of the population was 65 years of age or over. By 1985, Social Security Administration actuaries estimate, 11.7 percent of the population was elderly. Because of this shift toward an older population,

Table 10

Payments into Medicare trust funds and percent distribution, by type of fund and source of income: Fiscal years 1971 and 1985

Year and source of income	Total		Hospital insurance trust fund		Supplementary medical insurance trust fund	
	Amount in billions	Percent distribution	Amount in billions	Percent distribution	Amount in billions	Percent distribution
1985						
Total	$75.5	100.0	$50.9	100.0	$24.6	100.0
Payroll taxes	46.9	62.1	46.9	92.0	—	—
General revenues	18.8	24.8	0.9	1.7	17.9	72.8
Premiums	5.6	7.4	0.0	0.1	5.5	22.5
Interest	4.3	5.7	3.2	6.2	1.2	4.7
1971						
Total	8.5	100.0	6.0	100.0	2.5	100.0
Payroll taxes	5.0	58.2	5.0	82.5	—	—
General revenues	2.1	24.8	0.9	14.5	1.2	49.5
Premiums	1.3	14.7	—	—	1.3	49.8
Interest	0.2	2.3	0.2	3.0	0.0	0.7

NOTE: 0.0 denotes less than $50 million.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

the percentage of the total population potentially eligible for Medicare on the basis of age has increased more than 24 percent. That increase, coupled with medical care prices rising faster than overall prices and significant increases in the intensity of services delivered, has put the solvency of the Medicare HI trust fund in jeopardy. The DRG payment system has helped the situation, but it is not a solution in and of itself.

From 1977 to 1984, Medicare hospital expenditures grew at an average annual rate of 15.5 percent, compared with only a 12.5-percent increase in overall hospital spending. In 1985, growth of Medicare spending for hospital care increased 10.1 percent, again outpacing the growth in total spending for hospital care (7.3 percent).

Despite a freeze on physicians' fees and limits on reimbursement for laboratory services, historical trends in the rate of growth in Medicare spending for physicians' services were replicated in 1985. Over the past decade, average annual growth in physician expenditures reimbursed by Medicare considerably exceeded the growth in overall expenditures for physicians' services. In 1985, growth in Medicare spending for physicians' services jumped 16.4 percent while growth in overall physician spending increased only 9.9 percent.

Medicare reimbursement for home health agency services has grown significantly, increasing at an average annual rate of 24 percent since 1968. Home health care reimbursements in fiscal year 1985 were $2.3 billion, up 22.9 percent. Most Medicare payments for home health agency care are included in the category "other professional services." The remainder, used to reimburse care provided by hospital-based agencies, is reported under "hospital care."

Home health agencies certified by Medicare are required to submit annual cost reports. A recent analysis of cost reports for 1982 submitted by home health agencies that are not part of a hospital or nursing home indicate that agency costs for services and for medical equipment and supplies provided to Medicare patients represented approximately 50 percent of total agency costs.

Beginning in October 1983, Medicare expanded hospital insurance benefits to include coverage of hospice care for terminally ill Medicare beneficiaries. These expenditures, $2 million in fiscal year 1984 and $15 million in fiscal year 1985, are categorized as "other professional services" in the national health expenditures statistics.

Medicaid—In 1985, the Medicaid program spent $39.8 billion on behalf of low-income individuals for personal health care, an amount 9.4-percent higher than spending in the previous year. Medicaid is heavily weighted toward institutional care, and program funds are equally split (37 percent each) between hospital and nursing home care.

Medicaid is funded jointly by the Federal and State/local governments. The Federal Government sets minimum requirements for eligibility and services, allowing State governments considerable flexibility in designing the total scope of the program within the constraints of the State budgetary process.

The Federal Government requires that all people receiving income benefits under the Supplementary Security Income program (covering aged, blind, and disabled individuals) and families qualifying for Aid to Families with Dependent Children automatically qualify for Medicaid benefits. State governments may, at their option, extend the program to cover "medically indigent" individuals or families.

The Federal Government also defines minimum services which must be provided to Medicaid recipients. These services include inpatient and outpatient hospital services; physician care; skilled nursing home care; rural health clinic services; laboratory and X-ray services; home health care services to individuals 21 years of age or over; early and periodic screening, diagnosis, and treatment for individuals under 21 years of age; and family planning services. State governments may opt to expand services to areas such as prescription drugs and intermediate care facility services.

Given these minimum standards of eligibility and required services, State governments have constructed their Medicaid programs, constrained by limits on the availability of State funds. With health care costs rising more rapidly than costs in other sectors of the economy, the proportion of State revenue needed to fund the Medicaid program is constantly an issue. From 1978 through 1981, Medicaid program costs increased more than 15 percent each year while State revenue rose at an average annual rate of only 11 percent. During this period, rapidly rising health care costs, higher unemployment in many States because of the recession, and Federal efforts to reduce the growth of its health-related budget left many State governments scrambling to modify the structure of their Medicaid programs.

In recent years, State governments have used their flexibility in designing their Medicaid program to deal with the funding crisis. Many have tightened eligibility rules, resulting in slight declines in the number of persons receiving care from 1977 to 1984. Unduplicated counts of recipients fell from a high of 22.8 million in 1977 to 21.6 million in 1982-84. In 1985, unduplicated counts rose slightly to 21.8 million. This increase resulted partly from the expansion of eligibility to cover pregnant women and specific groups of children in compliance with the Deficit Reduction Act of 1984. (This expansion was targeted to reduce overall utilization because increased emphasis on prenatal care will reduce the incidence of low-birthweight babies with multiple medical problems.) Services were cut back in some areas and expanded in others (particularly through the use of the home- and community-based waivers); preadmission screenings were required for nursing home care; inpatient days of care were limited and only specific facilities could be used—all to reduce utilization. Some State governments adopted new reimbursement rules such as prospective payment, DRG's, and competitive bidding for Medicaid hospital service contracts

in attempts to curb rising costs.

In 1985, 42 percent of all nursing home care was financed by Medicaid. Medicaid nursing home expenditures finance care for people who enter nursing homes as Medicaid eligibles as well as people who enter nursing homes as Medicare or private pay patients and who later exhaust their financial resources, becoming eligible for Medicaid. Data from the National Nursing Home Survey indicate that, in 1977, 22 out of every 100 persons 85 years of age or over lived in a nursing home. From 1985 to 2000, the number of Americans in this age group is expected to grow by 68 percent, from 2.9 million persons to 4.9 million. (During the same period, the population under 85 years of age is expected to increase by only 12 percent.) With more than one-third of all Medicaid dollars going for nursing care, the swelling ranks of the very elderly will put tremendous pressures on the Medicaid program in the future unless significant changes occur in the financing of long-term care.

Federal spending for Medicaid grew more than twice as fast as State and local Medicaid spending in 1985. Most of the rapid increase in the Federal share was caused by the lapse of provisions of the Omnibus Budget Reconciliation Act of 1981 that reduced Federal payments to States by 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984. State governments could offset those reductions by 1 percentage point for each of three conditions: operating a cost review program; having an unemployment rate 1½ times the national average; and operating a fraud and abuse recovery program yielding savings of at least 1 percent of the Federal share. In addition to the lapse of these cost reduction provisions, the Federal Government made offset payments in 1985 to States that met any of the three conditions in 1984, contributing to the higher growth rate in Federal spending.

In fiscal year 1986, the Medicaid program introduced a budget-neutral change in the calculation of the Federal medical assistance percentage. These rates, currently calculated every 2 years, will be calculated annually using personal income data more closely aligned to the time period to which the rate will be applied. This change will increase Federal funds to needy States at times more closely linked to the times when those funds are most needed.

Other government programs

In addition to Medicare and Medicaid, other public sources of financing for health care services exist (Table 11). They include the following.

Table 11

Expenditures for health services and supplies under public programs, by type of expenditure and program: Selected calendar years 1975-85

Program area	All expenditures	Personal health care									Administration	Public health activities
		Total	Hospital care	Physicians' services	Dentists' services	Other professional services	Drugs and sundries	Eyeglasses and appliances	Nursing home care	Other		
1985	Amount in billions											
Public and private spending	$409.5	$371.4	$166.7	$82.8	$27.1	$12.6	$28.5	$7.5	$35.2	$11.0	$26.2	$11.9
All public programs	165.2	147.5	89.8	24.1	0.6	3.6	2.7	1.5	16.5	8.6	5.8	11.9
Federal	117.2	112.6	71.6	19.7	0.3	2.8	1.4	1.3	9.4	6.0	3.2	1.4
State and local	48.0	34.8	18.2	4.4	0.3	0.9	1.3	0.1	7.1	2.6	2.7	10.5
Medicare[1]	72.3	70.5	48.5	17.1	—	2.0	—	1.2	0.6	1.1	1.8	—
Medicaid[2]	41.8	39.8	14.8	3.4	0.5	1.3	2.4	—	14.7	2.7	2.0	—
Federal	23.2	21.9	8.1	1.9	0.3	0.7	1.4	—	8.1	1.5	1.3	—
State and local	18.6	17.9	6.8	1.5	0.2	0.6	1.0	—	6.6	1.2	0.7	—
Other State and local public assistance programs	1.9	1.9	0.9	0.2	0.0	0.0	0.1	—	0.5	0.1	—	—
Veterans' Administration	8.7	8.7	6.9	0.1	0.0	—	0.0	0.1	0.7	0.8	0.1	—
Defense Department[3]	8.4	8.3	6.6	0.3	0.0	—	0.0	—	—	1.4	0.1	—
Workers compensation	8.2	6.3	3.2	2.6	—	0.2	0.1	0.1	—	—	1.9	—
Federal	0.3	0.3	0.2	0.1	—	0.0	0.0	0.0	—	—	0.0	—
State and local	7.9	6.0	3.0	2.6	—	0.2	0.1	0.1	—	—	1.9	—
State and local hospitals[4]	7.3	7.3	7.3	—	—	—	—	—	—	—	—	—
Other public programs for personal health care[5]	4.7	4.6	1.5	0.3	0.0	0.1	0.0	0.1	—	2.5	0.1	—
Federal	2.9	2.9	1.4	0.2	0.0	0.1	0.0	0.0	—	1.2	0.0	—
State and local	1.8	1.7	0.1	0.1	0.0	0.0	0.0	0.0	—	1.4	0.1	—
Government public health activities	11.9	—	—	—	—	—	—	—	—	—	—	11.9
Federal	1.4	—	—	—	—	—	—	—	—	—	—	1.4
State and local	10.5	—	—	—	—	—	—	—	—	—	—	10.5
Medicare and Medicaid[6]	113.5	109.7	63.3	20.4	0.5	3.3	2.4	1.2	15.3	3.3	3.8	—

See footnotes at end of table.

Table 11—Continued

Expenditures for health services and supplies under public programs, by type of expenditure and program: Selected calendar years 1975-85

Program area	All expenditures	Personal health care									Administration	Public health activities
		Total	Hospital care	Physicians' services	Dentists' services	Other professional services	Drugs and sundries	Eyeglasses and appliances	Nursing home care	Other		
1980	Amount in billions											
Public and private spending	$236.2	$219.7	$101.6	$46.8	$15.4	$5.7	$18.8	$5.1	$20.4	$5.9	$9.2	$7.3
All public programs	97.5	86.5	53.9	12.6	0.6	1.4	1.6	0.6	11.2	4.5	3.8	7.3
Federal	65.8	62.5	41.1	9.6	0.3	1.0	0.8	0.5	6.0	3.1	2.0	1.3
State and local	31.7	24.0	12.8	3.0	0.3	0.4	0.8	0.1	5.2	1.4	1.7	6.0
Medicare[1]	36.8	35.7	25.9	7.9	—	0.7	—	0.4	0.4	0.4	1.1	—
Medicaid[2]	26.5	25.2	9.6	2.4	0.5	0.6	1.4	—	9.8	0.9	1.3	—
Federal	14.5	13.6	5.2	1.3	0.3	0.3	0.8	—	5.3	0.5	0.8	—
State and local	12.0	11.6	4.4	1.1	0.2	0.3	0.6	—	4.5	0.4	0.5	—
Other State and local public assistance programs	1.6	1.6	0.6	0.2	0.0	0.0	0.1	—	0.7	0.1	—	—
Veterans' Administration	5.9	5.9	4.9	0.1	0.1	—	0.0	0.1	0.4	0.4	0.0	—
Defense Department[3]	4.2	4.2	3.4	0.1	0.0	—	0.0	—	—	0.6	0.0	—
Workers compensation	5.2	3.9	2.0	1.7	—	0.1	0.1	0.1	—	—	1.2	—
Federal	0.1	0.1	0.1	0.0	—	0.0	0.0	0.0	—	—	0.0	—
State and local	5.0	3.8	1.9	1.6	—	0.1	0.1	0.1	—	—	1.2	—
State and local hospitals[4]	5.8	5.8	5.8	—	—	—	—	—	—	—	—	—
Other public programs for personal health care[5]	4.2	4.1	1.7	0.3	0.0	0.1	0.0	0.1	—	2.0	0.1	—
Federal	2.9	2.9	1.5	0.2	0.0	0.0	0.0	0.0	—	1.1	0.0	—
State and local	1.2	1.2	0.1	0.1	0.0	0.0	0.0	0.0	—	0.9	0.1	—
Government public health activities	7.3	—	—	—	—	—	—	—	—	—	—	7.3
Federal	1.3	—	—	—	—	—	—	—	—	—	—	1.3
State and local	6.0	—	—	—	—	—	—	—	—	—	—	6.0
Medicare and Medicaid[6]	63.0	60.6	35.5	10.3	0.5	1.2	1.4	0.4	10.2	1.1	2.4	—

See footnotes at end of table.

- *Veterans' Administration* programs provide care to disabled, aged, and indigent veterans in Veterans' Administration hospitals, outpatient clinics, and nursing homes. Additional care is financed in community nursing homes and State veterans' nursing homes, as well as through the Civilian Health and Medical Program of the Veterans' Administration.
- *Department of Defense* (DOD) programs provide treatment to active and retired military forces, their dependents, and survivors in DOD hospitals and clinics. The Civilian Health and Medical Program of the Uniformed Services finances care required outside DOD facilities (primarily for dependents and retirees).
- *Indian Health Service* hospitals and clinics provide personal and public health services and also finance contract care services for Indians and Alaskan Natives.
- *Miscellaneous Federal health programs* help State and local governments to provide services to local populations. Block grants are given for maternal and child health; preventive health; primary care; and alcohol, drug abuse, and mental health. Programs other than block grants include community health centers, family planning, and migrant health.
- *Workers' compensation* programs provide benefits for work-related disability and death. In 1983, more than 30 percent of the benefits paid by these programs were for medical care. The remainder, not considered here, were cash payments to disabled workers or their survivors.
- *State and local government subsidies* may be given to hospitals providing community and psychiatric hospital services to citizens.
- *Other State and local government programs* fund medical care for the poor who are not eligible for Medicaid or services not eligible for Federal matching funds under Medicaid.
- *Other programs* provide temporary disability insurance, vocational rehabilitation, and school health services.

Philanthropy and industrial inplant services

Funds for personal health care from private philanthropic organizations totaled $2.5 billion in 1985. Administrative and fundraising expenses of private charities and philanthropic support of research and construction amounted to $6.4 billion.

Some health care is provided directly by industrial employers to employees through inplant health

Table 11—Continued

Expenditures for health services and supplies under public programs, by type of expenditure and program: Selected calendar years 1975-85

Program area	All expenditures	Personal health care									Administration	Public health activities
		Total	Hospital care	Physicians' services	Dentists' services	Other professional services	Drugs and sundries	Eyeglasses and appliances	Nursing home care	Other		
1975	Amount in billions											
Public and private spending	$124.3	$117.1	$52.4	$24.9	$8.2	$2.6	$11.9	$3.2	$10.1	$3.8	$4.0	$3.2
All public programs	51.3	46.3	28.9	6.6	0.5	0.6	1.0	0.2	5.6	2.9	1.8	3.2
Federal	33.8	31.4	20.1	4.7	0.3	0.4	0.5	0.2	3.2	2.1	1.2	1.2
State and local	17.5	14.9	8.8	1.9	0.2	0.2	0.5	0.1	2.5	0.8	0.7	1.9
Medicare[1]	16.3	15.6	11.5	3.4	—	0.2	—	0.1	0.3	0.1	0.7	—
Medicaid[2]	14.2	13.5	4.8	1.9	0.4	0.2	0.9	—	4.8	0.6	0.6	—
Federal	7.9	7.6	2.7	1.0	0.2	0.1	0.5	—	2.7	0.3	0.4	—
State and local	6.2	6.0	2.1	0.8	0.2	0.1	0.4	—	2.1	0.2	0.3	—
Other State and local public assistance programs	0.9	0.9	0.3	0.1	0.0	0.0	0.1	—	0.3	0.0	—	—
Veterans' Administration	3.5	3.5	2.9	0.0	0.1	—	0.0	0.0	0.2	0.3	0.0	—
Defense Department[3]	2.8	2.8	2.2	0.1	0.0	—	0.0	—	—	0.5	0.0	—
Workers compensation	2.4	2.0	1.0	0.9	—	0.1	0.0	0.0	—	—	0.4	—
Federal	0.1	0.1	0.0	0.0	—	0.0	0.0	0.0	—	—	0.0	—
State and local	2.4	2.0	1.0	0.9	—	0.1	0.0	0.0	—	—	0.4	—
State and local hospitals[4]	5.2	5.2	5.2	—	—	—	—	—	—	—	—	—
Other public programs for personal health care[5]	2.7	2.7	0.9	0.2	0.0	0.0	0.0	0.0	—	1.4	0.0	—
Federal	1.9	1.9	0.8	0.1	0.0	0.0	0.0	0.0	—	0.8	0.0	—
State and local	0.8	0.7	0.1	0.1	0.0	0.0	0.0	0.0	—	0.6	0.0	—
Government public health activities	3.2	—	—	—	—	—	—	—	—	—	—	3.2
Federal	1.2	—	—	—	—	—	—	—	—	—	—	1.2
State and local	1.9	—	—	—	—	—	—	—	—	—	—	1.9
Medicare and Medicaid[6]	30.2	28.9	16.3	5.2	0.4	0.4	0.9	0.1	5.1	0.5	1.3	—

[1]Total Federal expenditures from trust funds for benefits and administration. Trust fund income includes premium payments paid by or on behalf of enrollees.
[2]Includes funds paid into the Medicare trust funds by States under "buy-in" agreements to cover premiums for public assistance recipients and for people who are medically indigent.
[3]Includes care for retirees and military dependents.
[4]Expenditures not offset by revenues.
[5]Includes program spending for maternal and child health; vocational rehabilitation medical payments; temporary disability insurance medical payments; Public Health Service and other Federal hospitals; Indian health services; alcoholism, drug abuse, and mental health; and school health.
[6]Excludes "buy-in" premiums paid by Medicaid for supplementary medical insurance coverage of aged and disabled Medicaid recipients eligible for coverage.

NOTE: 0.0 denotes less than $50 million.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

services. Expenditures for these services, classified as "other health services," are estimated at $2 billion in 1985.

Direct patient payments

Patients and their families spent $106 billion for "out-of-pocket" health care expenses in 1985, an increase of 8.0 percent over 1984. The proportion of personal health care financed by direct patient payments, after many years of steady decline, has stabilized at 28-29 percent over the past 7 years, with a slightly lower level recorded for 1982.

Altogether, direct patient payments covered 28 percent of all personal health care services in 1985. The largest proportions (21 percent) of out-of-pocket spending went for purchase of physicians' services and for drugs and medical sundries—$22 billion for each. Out-of-pocket costs for hospital care amounted to $16 billion, or 15 percent of all direct patient payments. Despite the large out-of-pocket expenditures for hospital care, these payments amounted to only 9 percent of total hospital expenditures. In contrast, nursing home care relied heavily on out-of-pocket spending, 51 percent of that category's expenditures, which amounted to $18.1 billion in 1985.

With the efforts of business and governments to reduce the growth in health care spending, one might expect stronger increases in direct patient payments in 1984-85 than actually occurred Businesses have restructured their benefit packages to allow employees to select less comprehensive coverage or higher deductibles in exchange for other health and nonhealth benefits or lower employee premiums. On the other hand, employees using preferred provider organizations and health maintenance organizations often pay little or no deductible or

coinsurance, and the second opinions usually required before surgery are often free.

One might also have expected larger increases in direct patient payments by the elderly than was actually the case. The shortened length of stay for hospital services for the population 65 years of age or over should increase out-of-pocket payments by aged Medicare beneficiaries. The deductible is based on the average cost of a day of hospital care, which is increasing, and is applied to the first day of care per benefit period. Thus, out-of-pocket payments should account for a larger proportion of the total hospital bill for Medicare beneficiaries. However, some of these out-of-pocket costs are covered by Medigap policies.

There appear to be countervailing forces acting on out-of-pocket payments, with the net effect being little or no change in the percentage of personal health care costs being paid directly. However, the stability of direct patient payments over the past 3 years, as calculated for the national health expenditures statistics, may mask underlying trends in out-of-pocket costs. This category is not estimated directly but is calculated as a residual after the estimation of all known payers is completed. Therefore, it includes the net effect of all data errors. It also includes some items, such as nonpatient revenue sources in hospitals and nursing homes, for which explicit estimates are not made.

Special tabulations from the American Hospital Association indicate increases of one-half of a percent in the proportion of self-paid charges in non-Federal hospitals. Slight declines in the proportion of income from nonpatient operations (e.g., gift shops, parking lots, cafeterias) and from nonoperating revenue (e.g., contributions) offset some of the increases in the proportion of self-paid charges. The net effect is little change in the proportion of revenue from these sources, all of which are included by default in net patient payments.

Definitions, concepts, and data sources

Scope of National Health Accounts

The National Health Accounts (NHA) constitute the framework in which estimates of spending for health care are constructed. Spending is analyzed in two dimensions, types of spending and sources from which that spending is financed.

In the NHA, several types of spending are recognized. "Personal health care" is defined as therapeutic goods or services rendered to treat or prevent a specific disease or condition in a specific person. "Government public health activity" comprises spending designed to provide similar goods and services to a general population (for example, activities of the Centers for Disease Control). "Program administration" covers spending for the cost of running various government health care programs plus the net cost of private health insurance (the difference between premiums earned by insurers and the claims or losses for which they become liable). Finally, "research and construction" spending includes noncommercial biomedical research and the construction of health care facilities. The NHA aggregate spending figure is known as "national health expenditures."

The NHA, like all constructs, are of necessity arbitrary in their boundaries. A considerable amount of spending that many feel to be part of expenditures for health is excluded under the NHA definitions. For example, nutrition programs such as the Special Supplemental Food Program for Women, Infants, and Children are excluded. Programs designed to improve environmental and sanitation conditions are also excluded. Carried to an extreme, however, one could argue for the inclusion of additional types of spending (for groceries and housing, for example) with health care on the grounds that they, too, add to one's health. Such inclusions or exclusions are neither right nor wrong but depend solely on the purpose of the results. The purpose of the NHA is to provide a context within which Medicare and Medicaid spending can be analyzed. Therefore, the clinical nature of the NHA definition is most appropriate.

The type of product consumed or, in the case of services, the type of establishment providing the service determines what is included or excluded from the NHA. In the case of both goods and services, we have relied on standards generated in the Federal Government. Goods are classified according to the product codes used by the U.S. Bureau of the Census. Services are recognized when they are provided through establishments that fall into Standard Industrial Classification (SIC) 80 or through government operations that mimic that classification. Businesses producing like products are grouped into SIC's. Each business is assigned a code that identifies the broad and specific nature of its operation. The SIC codes recognized in the NHA are those in group 80, "Health Services" and are as follows.

SIC 801. Offices of physicians.
SIC 802. Offices of dentists.
SIC 803. Offices of osteopathic physicians.
SIC 804. Offices of other health practitioners (chiropractors, optometrists, podiatrists, therapists, etc.).
SIC 805. Nursing and personal care facilities.
SIC 806. Hospitals.
SIC 807. Medical and dental laboratories.
SIC 808. Outpatient care facilities.
SIC 809. Health and allied services, not elsewhere classified.

The definition of each classification is detailed in the *1972 Standard Industrial Classification Manual* (Executive Office of Management and Budget, 1972).

Different aspects of the National Heath Accounts are explored in other work performed in the Health Care Financing Administration, including a detailed examination of

private health insurance (Arnett and Trapnell, 1984); projections of health expenditures to 1990 (Arnett et al., 1986); estimates of personal health care spending by the aged population (Waldo and Lazenby, 1984); and estimates of personal health care spending by State (Levit, 1985).

Revisions to National Health Accounts

Revisions are made to the National Health Accounts each year to incorporate new data that become available. Generally, these revisions affect only the most recent years. It is for this reason that the last 2 years of estimates should be considered preliminary. Changes affecting longer time periods are occasionally incorporated when the methodology used to estimate expenditures changes, when more precise methods of incorporating existing data are implemented, or when benchmarked source data are released.

Revisions in the 1985 national health expenditures series are limited to 1980-85. These revisions include changes in the processing of hospital data; the inclusion of revised nursing home input price index data in the nursing home estimates; incorporation of the December 1985 benchmark revisions to the National Income and Product Accounts data used in the estimates for drugs and medical sundries and for eyeglasses and appliances; revisions to the basic data used to estimate Medicare outlays; and incorporation of an improved method for integrating Census of Governments information with data produced in the annual U.S. Department of Commerce's *Governmental Finances* report.

Revisions in the level of GNP estimates back to 1929, which resulted in lower health expenditures as a percent of the GNP, are discussed at the end of this section.

Hospital care

Estimates of expenditures for hospital care represent all spending for both inpatient and outpatient hospital services in the Nation. Spending for drugs and other supplies associated with hospital services and for all services by hospital staff, including physicians salaried by the hospital, falls in this category.

Services of self-employed physicians in hospitals (surgeons, for example) are not counted as hospital expenditures. Anesthesia and X-ray services sometimes are classified as hospital care expenditures and sometimes as expenditures for physicians' services, depending on billing practices. Spending for hospital-based home health agency services and for nursing home units in hospitals is included in this estimate. In the 1985 *Hospital Statistics* publication of the American Hospital Association (AHA), 926 hospitals were reported to have nursing-home-type units in 1984. These facilities recorded 25.5 million inpatient days in nursing-home-type units, amounting to 7.2 percent of all inpatient days reported by hospitals.

The category of hospital care is a measure of outlays for hospital services. The costs of providing service, as well as any profits or losses recorded by any of the facility's operations, are incorporated. To measure outlays, total revenue data from community hospitals are used. For all Federal hospitals, outlay data are obtained from the agencies responsible for operating these facilities. For non-Federal noncommunity hospitals, total expenses are the only available data and are used to measure expenditures for hospital services.

The estimates of expenditures for non-Federal hospital care are based on data on hospital finances collected by the AHA as part of the Annual Survey of Hospitals. Community hospital expense data are converted to revenue using data provided in the AHA *Hospital Statistics* publications. A time series of expenses or "revenue" for each non-Federal hospital is constructed from the AHA data. Adjustments are made to expenses or "revenue" to account for periods not covered by reported financial data. In addition, deductions are made to eliminate duplication of expenses or "revenue" because of overlapping financial years. All expense or "revenue" data are converted to calendar years based on the financial year dates reported by individual hospital facilities and on monthly panel survey data. Data from the AHA monthly panel survey of community hospitals are used along with NHA estimates of sources of funding as a guide in estimating the percentage change in hospital expenditures for periods more recent than the latest annual survey.

Services of health professionals

Expenditures are reported under the categories of services of physicians, of dentists, and of other health professionals. Spending in these categories is for services rendered in establishments of health professionals. The precise category into which each expenditure falls is determined by the Standard Industrial Classification of the establishment in which service is provided. (See the discussion of SIC codes under Scope of National Health Accounts.) Basically, "physicians" comprise the offices of medical doctors (SIC 801) and doctors of osteopathy (SIC 803) plus independent medical laboratories (SIC 8071). "Dentists" comprise the offices of doctors of dental surgery or doctors of dental medicine (SIC 802). "Other professional services" comprise services provided by establishments falling into SIC 804, part of 808, and 809, as well as home health agencies operating through establishments outside SIC 80 (usually through temporary help agencies).

Expenditures for the services of professionals working under salary for a hospital, nursing home, or other type of health care establishment are reported with expenditures for the service offered by the establishment. For example, care rendered by hospital residents and interns is defined as hospital care; services provided by nursing home staff nurses are included with nursing home care. The salaries of professionals serving in the field services of the Armed Forces are included with "other health services."

Until about 1977, estimates of expenditures for professional services were based primarily on statistics compiled by the Internal Revenue Service and published in *Statistics of Income—Business Income Tax Returns*. Business receipts (which exclude nonpractice income) for sole proprietorships, partnerships, and incorporated practices were summed to form the bulk of the estimate. In recent years, however, the timeliness and statistical variability of the Internal Revenue Service data deteriorated, and we ceased to rely on the *Statistics of Income* reports. Currently, data from the U.S. Census Bureau's Services Annual Survey provide important clues to the movement of spending for professional services. In addition, figures on employment, hours, and earnings in nongovernment health establishments, provided by the Bureau of Labor Statistics in the U.S. Department of Labor; estimates of price inflation provided by the Bureau of Labor Statistics' Consumer Price Index; and indirect measures of professional services, such as hospital admissions and inpatient days, are used to prepare the spending estimates in this report.

The physician estimates reported here contain some modifications to the "raw" figures on SIC 801, 803, and 8071. For example, we estimate the proportion of independent laboratory services that is billed through the physician and thus appears in the receipts of both physicians' office and laboratory; that proportion of receipts is subtracted from the total to avoid double counting. An estimate of fees paid to physicians for life insurance examinations is deducted because such services are not considered health care. (Currently, that deduction is implicit rather than explicit.) An estimate of salaried physicians' services provided through prepaid health plans such as health maintenance organizations, which do not fall into SIC 801 or 803, is added.

A modification also is made to the dentist "core" of SIC 802. An estimate of expenditures for salaried services through prepaid dental clinics is added to the receipts of establishments in SIC 802. The receipts of dental laboratories (SIC 8072) are not included explicitly because all billings are assumed to be made through dentists' offices and thus to be included in expenditure estimates already.

"Other professional services" are estimated in two parts. Expenditures for home health services are estimated using Medicare program data and other inferential information on the industry. Services other than home health include private-duty nurses, chiropractors, and optometrists, among others. Estimates of other professional services are made using data from the Internal Revenue Service, the Census Bureau, and the Bureau of Labor Statistics. In early years, a portion of optometrists' receipts presumed to represent the dispensing of eyeglasses was deducted, as that money was reported under spending for eyeglasses and appliances. Currently, that proportion is carried forward in our estimate implicitly.

Consumer durables and nondurables

The category drugs and medical sundries and the category eyeglasses and appliances together cover spending for consumer purchases of medical durable and nondurable goods. The exact scope of products covered is determined by U.S. Census Bureau product codes used in the quinquennial census of manufactures and retail sales. Space does not permit an enumeration of the product codes included in our estimates. However, drugs and medical sundries include prescription and nonprescription drugs and "over-the-counter" products such as topical antiseptics, analgesics, and sanitary napkins. Expenditures for eyeglasses and orthopedic appliances include purchases or rentals of vision products, hearing aids, braces, and other durable medical equipment.

The figures shown in these categories include only spending for goods purchased from retail trade outlets by consumers. The value of goods provided to patients in hospitals and in nursing homes and those dispensed through health professionals is implicit in spending for those types of services.

With these categories we do not begin with a national total and then distribute that money among the various payers. Rather, we estimate spending separately for private and public sources of funds and combine the two sources to arrive at a national total.

The basis of our estimates of private spending for drugs and drug sundries and for eyeglasses and appliances is the estimate of personal consumption expenditures prepared by the U.S. Commerce Department's Bureau of Economic Analysis. These estimates, part of the broader estimate of the gross national product, are based in turn on the quinquennial Census of Retail Trade and the Bureau of Economic Analysis' Input/Output Tables of the United States. The numbers presented this year reflect the recent benchmark revisions to the GNP discussed later in this report. To estimate government spending for durables and nondurables, we rely on program statistics reported by the various government agencies, principally those that control the Medicaid program.

Nursing home care

Expenditures for nursing home care encompass spending in all nonhospital facilities or parts of facilities in which some level of nursing care is provided. Included are expenditures for services in all nursing homes certified by Medicare and/or Medicaid as skilled nursing facilities; those certified by Medicaid as intermediate care facilities for regular patients, as well as those for the mentally retarded (ICF/MR's); and all other homes providing some level of nursing care, even though they are not certified under either program.

The estimates of nursing home expenditures for facilities other than ICF/MR's are derived from revenue data obtained through the National Center for Health Statistics' National Nursing Home Survey. In years for which no revenue data are available, estimates are based on average employment and work hours of staff of nursing and personal care facilities (SIC 805), compiled by the

Bureau of Labor Statistics, and an index of prices paid by nursing homes for labor and nonlabor resources. The nonhospital portion of Medicaid expenditures for ICF/MR's is estimated from Medicaid financial data and added to the regular nursing home estimates to produce total nursing home expenditures.

Other personal health care

Personal health care expenditures that do not clearly fit into a category of spending or that are for unspecified purposes are aggregated here. Public expenditures in this category include spending for school health services, identified but unclassified expenses such as ambulance services reimbursed by Medicare, and public spending for which no service category can be identified. A substantial portion of the total is for care provided in Federal units other than hospitals, a residual amount that reflects the cost of running field and shipboard medical stations and military outpatient facilities separate from hospitals. Grants to community health centers are also included in this category. The only private expenditures in "other personal health care" are for operation of industrial onsite health services. This item is estimated using Bureau of Labor Statistics employment data and price inflation data.

Government public health activities

The Federal portion of government public health activities consists of outlays for the organization and delivery of health services, the prevention and control of clinical health problems, and similar health activities administered by various Federal agencies, chiefly within the U.S. Department of Health and Human Services. Expenditures by the Food and Drug Administration and the Centers for Disease Control represent an overwhelming proportion of Federal Government expenditures for public health activities. Data to construct this series come from *The Budget of the United States Government.*

The State and local portion represents expenditures of all State and local health departments, less Federal payments to the States and localities for public health activities. State and local expenditures channeled through the Maternal and Child Health and Crippled Children's programs are excluded. In addition, any State and local funding for health research and capital outlays for health facilities are excluded, as are expenditures of other State and local government departments for air pollution and water pollution control, sanitation, water supplies, and sewage treatment. The sources of data for State and local public health are the annual U.S. Bureau of the Census *Governmental Finances* and the periodic *Census of Governments* publications.

Program administration and net cost of insurance

In the National Health Accounts, program administrative expenses include nonpersonal health expenditures of private charities for health education, lobbying, fundraising, and other administrative costs. Administrative expenses of the Medicare, Medicaid, Veterans' Administration, Department of Defense, workers' compensation, Indian Health Service, and Maternal and Child Health programs are also included. Although administrative costs exist in other government programs, these costs cannot be separately identified.

Net cost is the difference between the amount of benefits received by privately insured persons and the amount they pay for insurance coverage. These payments may be made directly by the insured or indirectly by employers in lieu of wages. Benefits are counted on an incurred basis. Premiums, subscription income, and contributions for insurance coverage are counted on an earned basis and are adjusted for dividends and rate credits. In other words, the net cost of insurance is the amount retained by insurers for administrative and other operating expenses, additions to reserves, taxes, and profits after benefit payments have been made.

Medical research

Expenditures for medical research include all spending for biomedical research and research in the delivery of health services by private organizations and public agencies whose primary objective is the advancement of human health. Research expenditures of drug and medical supply companies are excluded. Because this type of research is treated as a business expense and is financed through sales of goods or services, its value is already included in personal health care expenditures; to include it again in research would result in double counting.

Amounts spent on Federal medical research are derived from agency reports collected and compiled by the National Institutes of Health. The amounts shown for State and local governments and for private expenditures are also based on estimates prepared by the National Institutes of Health (1985).

Construction of medical facilities

Expenditures for construction include the erection or renovation of hospitals, nursing homes, medical clinics, and medical research facilities. We do not include spending for the construction or renovation of private office buildings providing office and laboratory facilities for private practitioners, principally because we do not have any information on which to base such an estimate. For the same reason, we do not include spending for movable capital equipment. Amounts spent for construction of water treatment or sewage treatment plants and Federal grants for these purposes are excluded because the purpose of those facilities lies outside the boundaries of national health expenditures.

The value of construction is measured as "value put in place."

Such a valuation "books" the cost of construction as it is erected. In this way, the cost of a building is spread over several years.

The basic data source for construction statistics is the U.S. Census Bureau's C-30 survey of new construction. Modifications of State and local government construction are made to reflect a more thorough sample of such projects through another Census Bureau survey, data from which are published in *Governmental Finances*.

Direct patient payments

Direct patient payments consist of the cost of health care that people must pay themselves, as third parties in general do not cover all the expenses of health care. These payments include a variety of expenditures: out-of-pocket costs paid entirely by individuals when they purchase medical goods and services; coinsurance and deductible amounts paid by individuals as required by third-party programs; and amounts paid to providers of care over and above the usual, customary, or reasonable charges reimbursed by third parties. The category does not include health insurance premiums because some or all of those premiums are returned in the form of benefits during the year. Also excluded are coinsurance and deductible amounts paid by public programs or by private supplementary insurance programs such as Medigap, which are included with third-party payments.

Direct patient payments are calculated as a residual. Thus, this category contains the net effect of data errors. In addition, items for which we do not have an estimate—specifically, nonpatient revenue of hospitals and nursing homes—are included.

Private health insurance

Estimates of the amount of health care expenditures financed by private health insurance are derived from the data series on the financial experience of private health insurance organizations compiled and analyzed by the Health Care Financing Administration (Arnett and Trapnell, 1984). Data for these estimates are furnished by the Health Insurance Association of America, the National Underwriter Company, Blue Cross and Blue Shield Association, and a survey of self-insured health plans conducted by the Health Care Financing Administration.

Other private sources

Spending by business for inplant health services and spending by philanthropic organizations are included in this category. Currently, there is little information on the scope of spending by these sources. Consequently, we have used extrapolation of historical proportions to derive current estimates.

Government program expenditures

All expenditures for health care that are channeled through any program established by public law are treated in the National Health Accounts as a public expenditure. To be included, government program expenditures must have as their primary focus the provision of care or the treatment of disease. Nutrition, sanitation, and antipollution programs are excluded. As an illustration of these nuances, the U.S. Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children (WIC) provided $1.5 billion to supplement the diets of low-income pregnant women and mothers and their infants and children in fiscal year 1985. However, WIC, along with "Meals on Wheels" and similar programs, is not included in the National Health Accounts because it is viewed as a nutrition program rather than a health service program.

On the other hand, expenditures under worker's compensation programs are included with government health expenditures, even though they involve benefits paid by insurers from premiums that have been collected from private sources. Similarly, premiums paid by enrollees in the Medicare supplementary medical insurance program are treated as public rather than private expenditures because payment of benefits is made by a public program. However, coinsurance and deductibles required under Medicare are included among patient direct payments because they are paid directly by the beneficiary to the provider of service.

Statistics on Federal program expenditures are based, in part, on data reported by the budget offices of Federal agencies. Excluded from national health expenditures are outlays for education and training of health professionals, including direct support of health professional schools and student assistance through loans and scholarships. Payments by agencies for employee health insurance are included with other private health insurance expenditures rather than treated as a government expenditure.

In general, all spending by State and local government units for health care that is reimbursed neither by the Federal Government (through benefit payments or grants in aid) nor by patients or their agents is treated as State and local expenditures. State and local spending is the net of Federal reimbursements and grants in aid for various programs. As with Federal expenditures, payments for employee health insurance by State and local governments as employers are included under private health insurance expenditures.

Data on many State and local programs are collected by Federal agencies. Medicaid program statistics provide data on Title XIX and non-Title-XIX medical vendor payments (State and local Medicaid and other State and local public assistance); the U.S. Bureau of the Census collects data on State and local health and hospital expenditures; and the National Center for Educational Statistics furnishes data used to estimate school health spending. In addition, the reporting system of the Public Health Association of State

and Territorial Health Officials furnishes data on State and local spending under the Maternal and Child Health and Crippled Children's programs.

Population

Official social security area population estimates are used to calculate health care spending per capita. The Social Security Administration adjusts U.S. resident population estimates obtained from the Census Bureau to account for the net census undercount and for people residing outside the 50 States and the District of Columbia who are covered by social security. Covered people residing outside the United States include members of the Armed Forces; U.S. civilian residents of Puerto Rico, the Virgin Islands, Guam, and American Samoa; Federal civilian employees; crew members of merchant vessels; and other U.S. citizens. Health care outlays for people residing outside the United States are included in data from both public and private funding sources.

Gross national product

The gross national product provides a backdrop against which spending for health care can be compared. Like national health expenditures, it is an estimate produced from a construct, in this case the National Income and Product Accounts. GNP estimates are calculated by analysts in the U.S. Commerce Department's Bureau of Economic Analysis.

The GNP is a measure of the value of goods and services produced during a given time period by U.S. resources. As such, it approximates the "income" from which national health expenditures must be paid. That the share of our GNP going to health care has been rising over the last two decades indicates that an increasing part of our Nation's income is being consumed by health care.

Because the GNP is estimated and is the product of a construct, it is subject to revision from time to time. Annual estimates of the GNP are revised in each of the 3 following years. In addition, every 5 years, after the quinquennial economic census, estimates are revised back a decade. Also, changes to the framework of the National Income and Product Accounts may necessitate revisions as far back as to 1929.

A number of revisions were made to the GNP at the end of 1985. Significant amounts were added to the GNP to reflect transactions missed in the basic data sources. Because the GNP was revised upward and national health expenditures were not, the share of the GNP reported in this year's estimates as attributable to health spending, going back in time, dropped about one-half of a percent. In the future, as we perform a benchmark revision of the National Health Accounts to reflect many of these same data considerations, the share of the GNP accounted for by health may change again.

In theory, almost all national health expenditures are included in the GNP. (An exception is the annual "profit" of nonprofit hospitals and nonprofit insurers, which by definition is not included in the GNP.) However, the money cannot always be identified very easily because of the nature of the National Income and Product Accounts, in which expenditures are grouped by type of consumer rather than by product class. For example, out-of-pocket spending; private health benefits; and benefits from Medicare, Medicaid, workers' compensation, and temporary disability programs are all classified as personal consumption, but other public programs are classified as government spending. "Consumer" spending in government hospitals is aggregated with tax payments rather than personal consumption. Consequently, it is difficult, or tedious at least, to extract total spending for health from the National Income and Product Accounts. Therein lies the major advantage of the National Health Accounts.

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